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A Look At Illinois' HMO

Illinois Medicine

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OF MEDICINE

Seminar examines legal requirements for Illinois medical residency programs

TEMPORARY LICENSES and "moonlighting" headed the agenda at a seminar for residency program directors held last month in Chicago.

Eighty-six residency program directors from across Illinois gathered at the Illinois Department of Professional Regulation offices to discuss the 1987 Medical Practice Act and its 1988 amendments. Confusion regarding program directors' responsibilities under the Act prompted the seminar, which was co-sponsored by the Illinois State Medical Society and the Department.

"There is a need for all physicians, especially for those involved in training physicians, to know the provisions of the Medical Practice Act," said Boyd E. McCracken, Sr., M.D., chairman of the ISMS Council on Education and Manpower and a seminar planner. "Understanding of educational requirements and limitations of temporary licensure is vital to ensure the quality and legality of your program and its resident activity." The seminar, he said, was an ideal opportunity to enhance communication.

Moderator Donald F. Pochyly, M.D., a member of the ISMS Council on Education and Manpower, set the tone for the seminar.

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HMOs weather the storm

by Karen Sandrick

WITHOUT A DOUBT, 1987 and 1988 were bad years for Illinois health maintenance organizations (HMOs). In 1987, approximately 50% of the state's HMOs reported operational losses, and "more HMOs reported losses for the first six months of 1988 than reported losses for all of 1987," said Arnold Dutcher, an examiner with the Illinois Department of Insurance.



The next few years also should be tough for HMOs, and while some may not survive, those that do will be strong.

In the last two years, HMOs in the state of Illinois have exploded, doubling or tripling in some markets, particularly in the Chicago metropolitan and suburban areas.

"The Chicago market is probably more competitive than just about any other market in the country," said Barry Averill, president of the Illinois Association of HMOs. "Twenty-six HMOs have entered the market in the last few years; just about every national HMO has opened up a branch in Chicago; and a lot of hospitals, to retain marketshare, have developed HMOs of their own."

Because the Chicago HMO market has been so hotly contested, price competition has become fierce. "The newer entrants into the Chicago market priced their products low in order to get marketshare, and that caused the more mature plans to keep their prices low in order to compete," observed Averill, who is also president of the 157,470-member Michael Reese Health Plan, Chicago.

As a result, "the HMOs have not been charging rates that reflect the cost of being in business," Dutcher stated.

In downstate Illinois, there are not nearly as many HMOs as there are in Chicago. Nonetheless, six out of seven downstate HMOs reported operational losses in 1987.

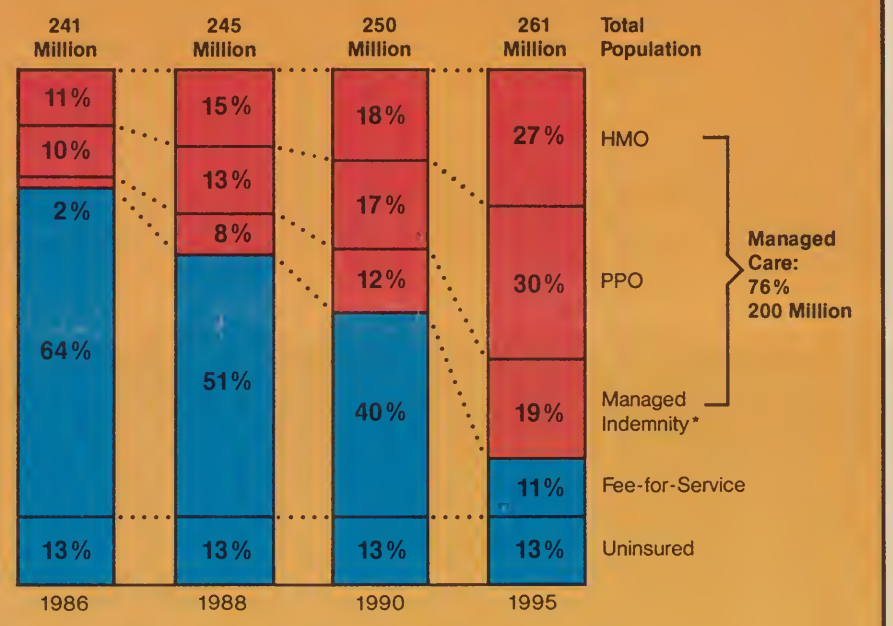
Competition has not been an issue for these HMOs, but high costs have. "There are additional costs of doing business downstate," said Dutcher. "The HMOs operate over a larger geographic area, which makes them more expensive. Plus, there are not as many competing medical providers; so downstate HMOs have more difficulty negotiating provider contracts," he added.

Illinois HMOs are not so different from HMOs in other parts of the country. "If you look at national results, you'll find that 1986 and 1987 were not good years," said Frank E. Nicholson, vice-president of HMO Illinois, the largest HMO in the state,

(continued on page 11)

TRENDS IN U.S. HEALTH INSURANCE COVERAGE

Some Analysts Project That 76% of the U.S. Population Will Be Covered by Managed Care Programs by 1995



*Managed indemnity refers to regular indemnity insurance with significant controls such as utilization review, second opinion programs, mail order prescription programs, etc.

Source of Data: HCFA, *Modern Healthcare*, InterStudy, The Wilkerson Group

Reprinted by permission from *Drug Topics*, Medical Economics Company, Oradell NJ, 1988 (as excerpted in *Medical Benefits*, Kelly Communications, Charlottesville VA, April 15, 1988)

Good Samaritan umbrella extended

THE ILLINOIS Appellate Court for the first district ruled on November 28, 1988, that the civil damage protections of the Illinois Good Samaritan Act can extend to physicians responding to an emergency in a hospital setting.

Matviuw v. Johnson concerned emergency care given by Dr. William Matviuw in April, 1983, when another physician's patient at Sherman Hospital, Elgin, suffered cardiac arrest. Dr. Matviuw, who was summoned by nurses to assist when the patient experienced respiratory and cardiac arrest, was not able to resuscitate the patient.

Although the decision does not bind trial judges outside the first district, it establishes an important precedent in Illinois law. The court held that a physician who in good faith and without prior notice of the illness or injury provides emergency care without a fee to a person in a hospital is not liable for civil damages absent willful or wanton misconduct.

It has been predicted that the case will be appealed to the Illinois Supreme Court. ▲

ISMS refutes charges of M.D. Medicare "gouging"

ISMS BOARD OF TRUSTEES Chairman Harold L. Jensen, M.D., denounced allegations levied by a consumer group last month that Illinois physicians overcharged Medicare patients.

"The study released today by the Illinois State Council on Senior Citizens' Organizations regarding the Illinois physicians' role in the Medicare program is misguided, and an attempt to drive a wedge between physicians and their Medicare patients," Dr. Jensen said. "The document both misuses data and draws conclusions which ignore basic facts about the Medicare program," he said.

Dr. Jensen was responding to statements regarding nonassigned billings. Anything beyond the Medicare "reasonable charge" was characterized as an "overcharge."

"Physicians must follow Medicare regulations in limiting charges for Medicare patients," he said. "Following government regulations in keeping charges limited is not 'overcharging.' In fact, the limits are almost always lower than charges for other patients."

The group claimed that Illinois physicians had overcharged Medicare beneficiaries $138 million in 1987, and that 64% of Illinois physicians who treat Medicare patients overcharge them.

"Approximately 70% of Medicare physician claims in Illinois are paid at the Medicare allowed amount," Dr. Jensen said. "The remainder do not exceed the government-determined maximum allowable actual charge."

The study called for a grassroots lobbying effort to pass mandatory Medicare assignment in Illinois, and the formation of a consumer campaign for that purpose.

Dr. Jensen pointed out that the Illinois State Legislative Committee of the American Association of Retired Persons (AARP) had not supported mandatory assignment in the last legislative session. "Last year alone, this legislation was defeated in 12 states," he said. "Those 12 are among the 46 that do not have mandatory assignment laws."

Approximately 70% of Medicare physician claims in Illinois are paid at the Medicare allowed amount. The remainder do not exceed the government-determined maximum allowable actual charge.

The group's creativity extended beyond interpretation. Their messages were delivered to the ISMS Chicago offices by a group of senior citizens, who had been provided new lyrics to traditional holiday carols. At Dr. Jensen's direction, the seniors, who were singing the "carols" outside in the cold, were served hot chocolate and coffee in the ISMS building lobby.

"Seniors who are concerned about what their medical care is going to cost should raise the issue with their individual physicians," Dr. Jensen concluded. "One-on-one discussions between doctor and patient will allow seniors to hear the truth about how both physicians and seniors are being treated by the Medicare system." ▲

From RBRVS to cigarettes and butterfat AMA delegation members juggle issues

THE AMERICAN MEDICAL Association House of Delegates convened December 4-7 in Dallas. Illinois was represented by 20 delegates and 20 alternates, who evaluated resolutions and presented testimony.

The most controversial issue before the House was the AMA response to the "National Study of Resource-Based Relative Value Scales for Physician Services." This mammoth document was completed only two months before the meeting, and the AMA evaluation had required six weeks' study.

A series of impromptu weekend meetings enabled the ISMS Committee on Third Party Payment Processes (TPPP) to develop an analysis for the delegation prior to floor debate. Arthur R. Traugott, M.D., Champaign, a member of the delegation and also chairman of the TPPP committee, said that Illinois' was among the best prepared delegations.

"Ours was an informed delegation," he said. "We understood the proposal, its implications and the overall picture. Our single most important contribution to this debate was that we raised the balance billing issue and insisted that physicians have a right to make a choice on assignment. We used the report to preserve balance billing. Until we find a more rational way to establish physician payments and fees, we need to maintain balance billing."

Illinois' understanding was also enhanced by the fact that two delegates, Alfred J. Clementi, M.D., Arlington Heights, and P. John Seward, M.D., Rockford, had input early in the process. Dr. Clementi actually participated as a surgical specialist subject in the study. (Although this did not prevent him from questioning some of the statistical findings in debate.) Dr. Seward, chairman of the AMA Council on Legislation, had served on the six person AMA study committee which had structured their board's recommendations.

The delegation focused on technical flaws, primarily in pre- and post-service work, relative practice costs and amortized specialty training costs. They militated for a "blending transition," in which physician payments would be determined in increasing proportion by an RBRVS-based indemnity payment schedule and in decreasing proportion by the current CPR payment system.

Sexual harassment, cigarettes and budgets

There was considerable reference committee and floor discussion on a proposed study of sexual harassment and sexual relationships between medical trainees (medical students and residents) and faculty supervisors.

Illinois Delegation members Lawrence L. Hirsch, M.D., of Northbrook and Gail Williamson, M.D., of Brookfield both spoke on the floor of the House. Dr. Williamson spoke on behalf of the Resident Physicians Section. Eventually, the House agreed that the AMA should study sexual harassment and sexual exploitation between medical trainees and their faculty supervisors.

The Resident Physicians Section also asked the AMA to draft model state legislation to allow identification of tobacco as a contributing factor on death certificates. Henrietta Herbolsheimer, M.D., of Chicago and Dr. Hirsch urged that this resolution be referred rather than adopted. The cause of death on death certificates is a clinical factor, they argued, and smoking was behavioral. They argued this was a "social" cause, and had no place on death certificates. The House eventually adopted an amended resolution.

Regional differences surfaced when the Midwest dairy states took on the California delegation. Resolution 37 from California asked the AMA to effect changes needed to identify 2% butterfat content as the level for regular milk and 1% as standard for lowfat milk. Wisconsin argued that there is no such thing as "regular" milk, but there is whole milk. Furthermore, Wisconsin informed California, a cow would continue to give whole milk whether or not she was told to give 2%. Joan Cummings, M.D., of Glen Ellyn, argued that children and the elderly need the nutrition of whole milk. She also said that changing the label of a product subverts education. The House defeated this resolution.

Furthermore, Wisconsin informed California, a cow would continue to give whole milk whether or not she was told to give 2%.

This was the first AMA House meeting where John Ring, M.D., of Mundelein served as chairman of the AMA Board of Trustees. Alfred J. Clementi, M.D., of Arlington Heights was recently appointed to the AMA's Council on Long Range Planning and Development. Harry A. Springer, M.D., of Evanston was chief teller at the meeting. Two delegates, Fred Z. White, M.D., of Chillicothe and Jere E. Freidheim, M.D., of Burr Ridge served on reference committees.

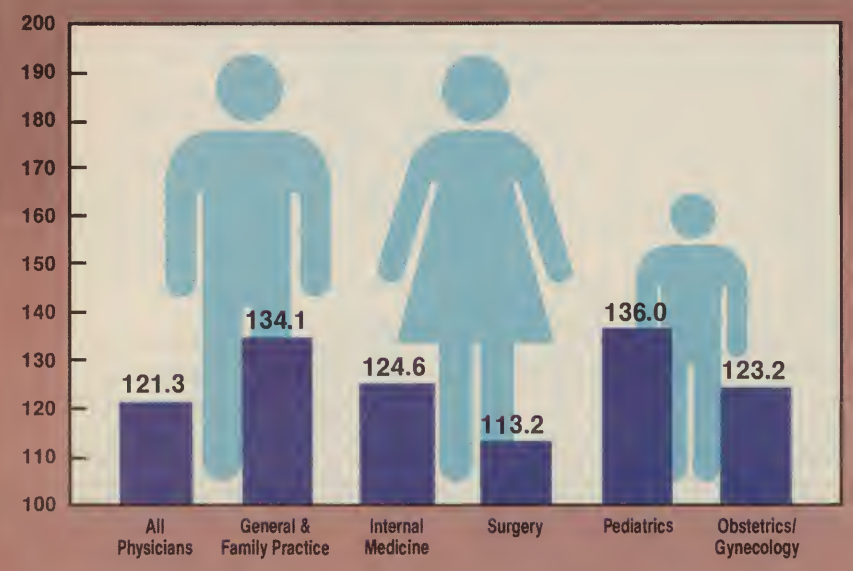
George T. Wilkins, M.D., of Granite City was elected chairman of the Illinois delegation, succeeding Robert C. Hamilton, M.D., of Chicago. New vice chairman is Alfred J. Clementi, M.D.

This was the last meeting for Joseph P. O'Donnell, M.D., of Glen Ellyn, who was honored for his 15 years of service on the delegation. ▲

Physician Facts

MEAN NUMBER OF TOTAL PATIENT VISITS PER WEEK—BY SPECIALTY[1]

East North Central Region of U.S.[2]



[1]*Excludes physicians in psychiatry, radiology, anesthesiology and pathology but otherwise includes physicians in specialties not listed separately*

[2]*Includes Illinois, Indiana, Michigan, Ohio, Wisconsin*

Source of Data: American Medical Association: *Socioeconomic Characteristics of Medical Practice*, 1987

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News from the Illinois Department of Public Health

by Judy Alsofrom

PUBLIC HEALTH REPORT

ALL PREGNANT WOMEN should be screened for Hepatitis B surface antigen (HBsAG), urges the Illinois Department of Public Health (IDPH).

IDPH is following the advice of an advisory committee of the federal Centers for Disease Control (CDC) issued in June, 1988. Previous 1984 CDC guidelines recommended only screening high-risk pregnant women. The CDC changed its guidelines following studies conducted in several major inner city hospitals that showed 35%-65% of all HBsAG-positive women would not have been identified by using the 1984 guidelines.

High risk groups are not always obvious to physicians, adds Carl Langkop of IDPH's division of infectious diseases. In one study, 40% of obstetricians surveyed could name no more than two groups at high risk for hepatitis B virus infection (HBV), and only 28% knew the recommended treatment for infants born to HBV-carrier mothers, according to *Morbidity and Mortality Weekly Report*. CDC officials have also expressed concern that physicians might miss high-risk women because of "reluctance" to question patients about drug use and past sexual histories.

The call for universal screening of pregnant women for HBsAG is supported by the American College of Obstetricians and Gynecologists and the American Academy of Pediatricians.

The call for universal screening of pregnant women is supported by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatricians (AAP).

Among recommendations from the CDC and IDPH are calls for:

—Routine testing of all pregnant women for HBsAG during an early prenatal visit;

—Treatment of infants born to HBsAG-positive mothers with hepatitis B immunoglobulin (HBIG) intramuscularly (IM) and HB vaccine IM preferably within 12 hours of birth.

—Testing of treated infants at 12-15 months;

—Testing household members and sexual partners of HBV carriers identified through prenatal screening to determine susceptibility to HBV infection and, if susceptible, administer HB vaccine.

IDPH HAS ISSUED new regulations regarding the reporting of HIV infections to local health authorities, as required by legislation passed by the state in 1987.

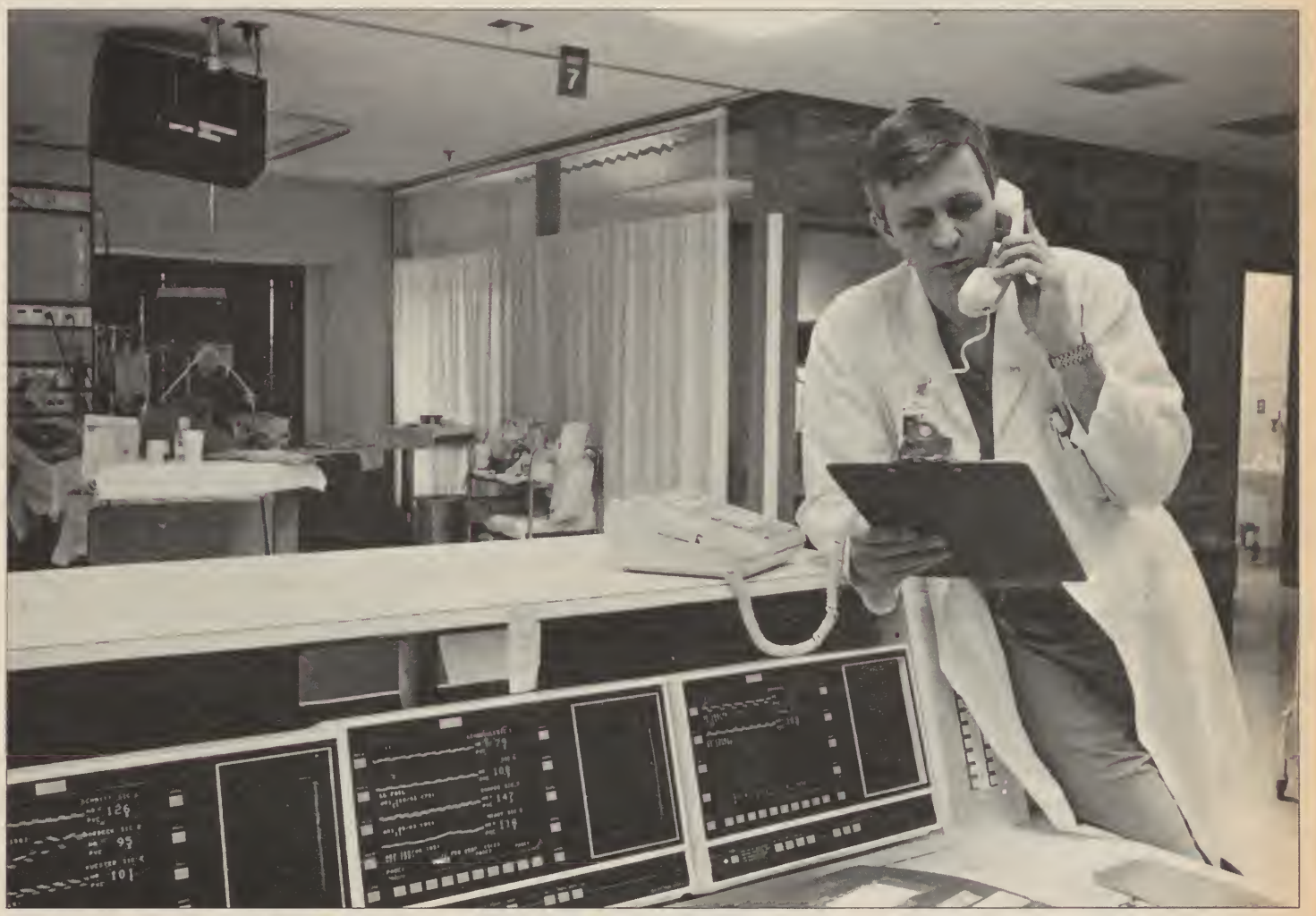
All HIV-positive infections must be reported by physicians, hospitals, and blood banks within seven days after receiving confirming laboratory evidence (repeatedly reactive ELISA tests and positive Western Blot assay or Indirect Fluorescent Antibody test).

The reporting of HIV positives is done without name identifiers; however, cases of AIDS and ARC are reported by name.

IDPH's LANGKOP alerts physicians to yet another public health problem—*salmonella enteritidis,* which until last year seemed to be confined to cases on the East Coast. Contagion is linked to uncooked or partially cooked eggs.

A recent small cluster of cases in the Middle West was tied to the contaminated interiors of fresh eggs and the *salmonella enteritidis* bug was found in the ovaries of adult hens, which, according to Langkop, "supports the idea of the transovarian transmission of *salmonella enteritidis* to the interior of the whole egg."

Physicians should be aware of this problem and warn patients, Langkop says. For example, baby food should not be blended in the same appliance that previously blended raw eggs, without a thorough cleansing. ▲



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Editorials

On the going and the getting there

This first issue of *Illinois Medicine* has been a long time coming. It's been two years since an all-member survey showed that we needed to evaluate the Society's communications program. Those two years have been filled with audits and surveys and focus groups and interviews. Now, at last, we know where we were going.

At least we know what *Illinois Medicine* will look like, in a general way. What it will try to do, in a general way. To meet a need. To satisfy a demand. To create a dialogue.

We have a formal statement of purpose: "*Illinois Medicine* is published by the Illinois State Medical Society to bring Illinois physicians balanced, accurate news and comment on health care issues and professional concerns. Circulation to community leaders is intended to stimulate dialogue and articulate timely, relevant information on public policy matters. Content is structured to challenge, motivate and assist physicians in communicating with patients, colleagues and the public."

Those are high-minded and ambitious goals; we may not pass muster at every attempt. But if you fill this page with letters to keep us on track, we might occasionally come close. And we can all enjoy the challenge. At least until the next issue.

A sight to behold

It was the best of times and it was the worst of times. AMA's report on the long-awaited and much maligned Resource-Based Relative Value Scale—2000 pages of technical jargon—had arrived just two weeks before. But on December 6 in Dallas, when the dust had settled on the floor of the AMA House, the Illinois delegation had the satisfaction of a job well done.

The Society's Committee on Third Party Payment Processes had worked a minor miracle: a concise, reasoned technical analysis which incorporated and anticipated political reality. Our delegates knew what they were talking about when it came to debating the RBRVS. And as a result, they weren't sidetracked by emotional issues.

The ISMS Board of Trustees had concluded in November that the great challenge of the RBRVS would be its potential use as a tool to splinter the profession. How more readily to divide specialists into armed camps than to apply a "conversion factor" to the value of their skills?

There was no turning away from it. In more than ten years of political and fiscal acrobatics, the most educated and endowed of nations had not come to grips with the duty to care for its own. Prospective payment systems, CPRs, economic indices, balance billing, MAACS and "inherent reasonableness," had exacerbated tensions over how the burden should be shared.

There is no guarantee that the Congress and HCFA will listen to the AMA, or care whether the AMA approves RBRVS or not. There are other payment systems, such as capitation, that Congress and HCFA may try to implement in spite of AMA protests. But there's no doubt that the final product will become a new standard for third party payors. The House approved the RBRVS with the full knowledge that they were changing the face of medicine.

The RBRVS was a face-off. The Illinois delegation, and their colleagues in the AMA House, found a way to deal with the series of red herrings which could so easily have meant a split decision. In the interest of "unity" they might have refused to take a position. They didn't. They took the tougher road and agreed that the Harvard RBRVS, if improved, could be an acceptable Medicare payment system.

When the system works, it's a sight to behold. ▲

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Trauma Center Anesthesia Regs

I read with interest the article entitled "Trauma Network to the Test." The article was very informative, but was incorrect in its summation at the conclusion.

The summary was correct for Level I facilities. However, under Level II facilities, you state, "A certified registered nurse anesthetist available within 30 minutes meets anesthesiology requirements." This is not a completely correct interpretation.

For Level II Trauma Centers, the current trauma code requires that anesthesiology services be in compliance with the Hospital Licensing Act and its rules. Such services shall be available within 30 minutes. The law permits direct patient care services by an anesthesiologist or a certified registered nurse anesthetist (CRNA).

The Hospital Licensing Act rules state "The anesthesia service shall be under the direction of a physician who has had specialized preparation and/or experience in the area or who has completed a residency in anesthesiology. An anesthesiologist, Board certified or Board eligible, is recommended."

Thus, by specific incorporation of the Hospital Licensing Act rules and regulations, IDPA Trauma Center rules require that anesthesia services provided by a Level II Center be under the direction of a physician who has had specialized preparation and/or experience in the area of anesthesiology or who has completed a residency in anesthesiology.

On behalf of the Illinois Society of Anesthesiologists, I request the correct interpretation of anesthesiology services for Level II Trauma Centers be published in an upcoming issue of *Illinois Medicine.*

Best wishes for the success of this new publication.

Bernard V. Wetchler, M.D.
Chairman
Committee on Governmental Affairs
Illinois Society of Anesthesiologists

AIDS Dental Care Study

As executive director of the Illinois State Dental Society (ISDS), I am writing to comment upon your article titled "AIDS Dental Care at Issue in Bill, Controversial Study" in the preview issue of *Illinois Medicine.*

ISDS agrees with the spokesman for the Center of Clinical Medical Ethics that research involving human subjects should include informed consent and that this study does not meet ethical standards. It is difficult to understand how the University of Illinois could approve a study which presupposes its conclusions on the one hand (note the title adopted prior to the study: "Unwanted Patients: Discrimination in Dental Practice") and which offends a significant segment of the community on the other by assuming that a professional actor can adopt props and background that will make the actor immediately identifiable as a homosexual.

Physicians and the Illinois State Medical Society (ISMS) in the past have been the target of ill-conceived efforts which hamper the effective delivery of health care. ISDS, though not directly affected, invariably has supported ISMS in its efforts to ward off these movements upon the theory that when medicine is attacked, dentistry will not be far behind.

In this case, it appears that dentistry is the first object of such an attack, but I predict that medicine will not be far behind.

I wish to also take this opportunity to clarify two other points in the article.

First, ISDS is quoted as stating that it declined to comment on the study. ISDS found out the details of the study only upon publication of the article! A reporter for *Illinois Medicine* did talk to our office prior to publication of the article, but he was unwilling to outline any details of the study prior to publication. As a result, I was not able to make any informed comment.

Secondly, the article notes that House Bill 3695 gave dentists the right to refer AIDS patients if the patient was referred to equal or superior treatment facilities, and that ISMS did not have a position on the bill because it did not affect physicians. As originally introduced, however, the bill gave this referral right to all practitioners, including physicians. The bill was later amended to involve only dentists after the first hearing in the House of Representatives.

ISDS believes that all patients, including those with AIDS, are entitled to dental treatment. ISDS has committed itself to assuring that every AIDS patient in the state of Illinois who needs dental treatment receives such treatment. However, ISDS further believes that such decisions should rest with the health professional, not with a government bureaucracy.

Robert A. Rechner
Executive Director
Illinois State Dental Society

A Clarification

Your preview issue included an article entitled, "Nursing Shortage Grows: Career Alternatives, Stress, Closing Programs Blamed." In that article the statement was made: ". . . and Saint Anthony's Hospital announced this summer they would close nursing programs." We do not intend to close our School of Nursing. We are currently developing our plans for a future College of Nursing. We are continuing our present program until we are ready to operate as a College of Nursing.

We are changing the educational level of our program in order to meet the health needs of our consumers and the changing trends in health care today.

Sister Mary Linus and Faculty
School of Nursing
Saint Anthony Medical Center
Rockford

ISMS "Spotlight on Illinois" stimulates and challenges

"SPOTLIGHT ON ILLINOIS," the 1988 ISMS All Member Conference gave more than 200 members a birds-eye view on a range of professional issues. From the semiannual Illinois State Medical Inter-Insurance Exchange Network breakfast to the Health Care Quality Improvement Act panel (see page 8), physicians found useful, challenging, presentations. Breakout sessions on the RBRVS, election projections and an *Illinois Medicine* workshop drew active crowds.

RBRVS: What next?

John J. Ring, M.D., Mundelein, chairman of the American Medical Association (AMA) Board of Trustees, addressed the Harvard Resource-Based Relative Value Study (RBRVS).

"As we evaluate this system," Dr. Ring said, "there will be some rearrangement in the relative values of how physicians are paid. And if the methodologies are correct, so be it. Our attitude is that we should do what is right, rather than what is politically expedient."

"In response," he said, "we would hope that the third party payors, particularly the government, would be equally responsible and do away with DRGs, MAACs, the participating/non-participating programs, and all the other zany schemes that only cost the government money, cost the profession aggravation and do nothing to enhance the quality of health care."

"No matter what we choose to do about the RBRVS, one thing should be obvious," Dr. Ring said. "It is going to change the face of medicine as we know it, and so it deserves your close attention. We cannot afford to sit on the sidelines to see which direction the government will take."

"The RVS fight is about more than just dollars," Dr. Ring said. "It is about sticking together. It is about lining ourselves up in such a way that we are not shooting each other when we start firing."

(*EDITOR'S NOTE*—The AMA House of Delegates met one month after this speech, and adopted the policy that the Harvard RBRVS, if sufficiently expanded and refined, would provide an acceptable basis for a Medicare indemnity system. The AMA Board was directed to continue its ongoing study of broad underlying issues, and to report on further developments at its spring, 1989 meeting. See page 2 for the Illinois delegation's view.)

Luncheon speaker paints the big picture

Uwe Reinhardt, Ph.D., Princeton's James Madison Professor of Political Economy, urged physicians to look carefully at what they are asking in compensation from the health care system, and challenged them to champion the ethical obligation to provide equal access to health care services for America's uninsured population.

He reviewed the rise in real dollar outlays per Medicare enrollee since 1981 for three Medicare categories; total Medicare (46 percent), hospitals (38 percent) and physicians (62 percent). This 62 percent figure, he said, is daily rubbed in the faces of the members of the federal Physician Payment Review Committee on which he sits and flung at sympathetic members of Congress in hearings. It is a number, he says, that physicians will have to come to grips with sooner or later, especially given the talk about expenditure caps.

Reinhardt believes that the uninsured in this country should have their health care paid through a pool, and that the pool must be a federal responsibility. "I was testifying in Congress, and I said to the people I was appearing before, 'Why don't you pledge to America's children that if they get sick, they will be taken to the nearest hospital and given prompt, quality medical care, whether their parents can pay for it or not.' Those are strong words," he said, "but that's what nationhood is all about."

The AMA Fault-Based Medical Liability Proposal

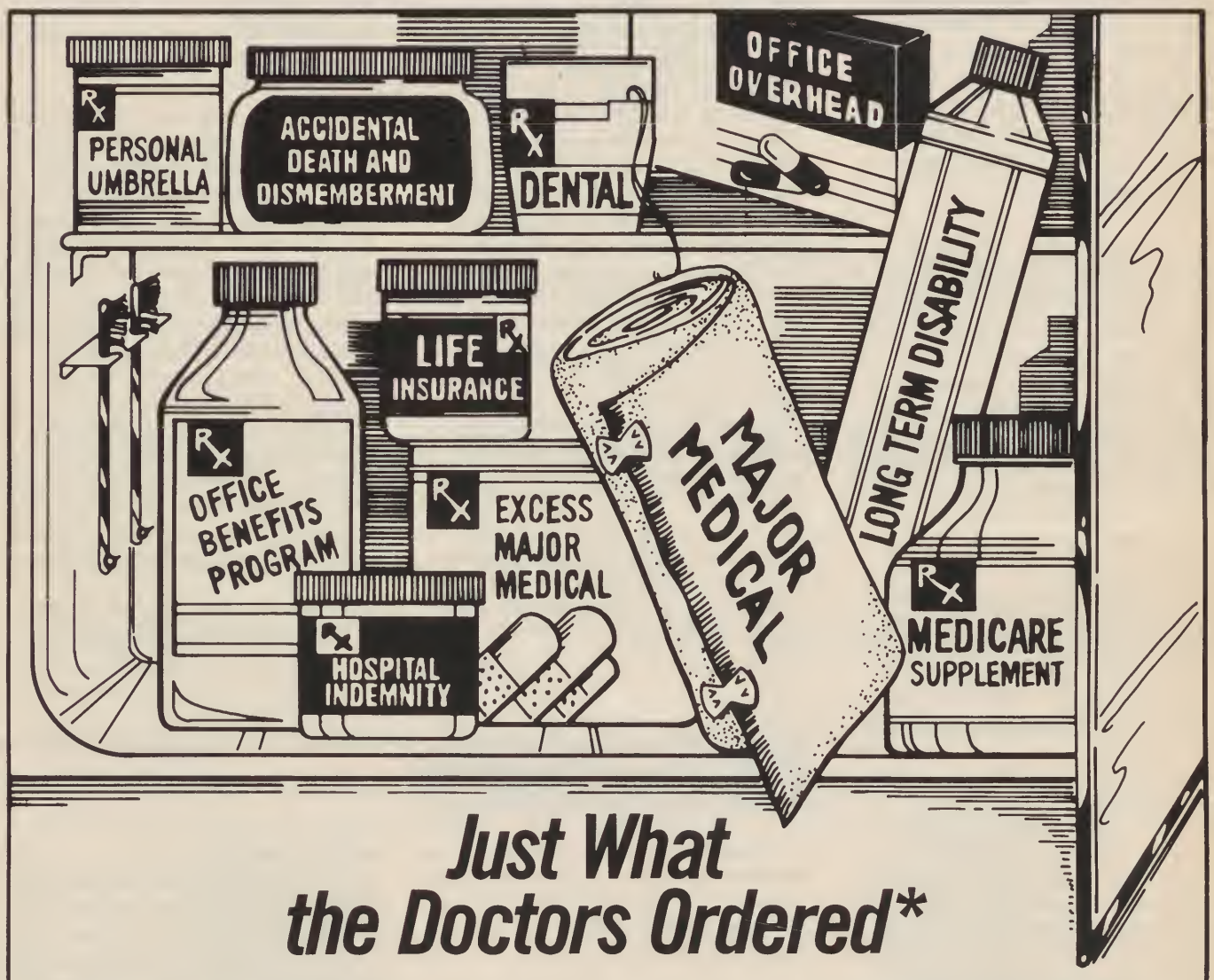
Alfred J. Clementi, M.D., Arlington Heights, a member of the AMA Professional Liability Advisory Panel and chairman of the Illinois State Medical Insurance Services Loss Prevention Committee, reported on a proposed alternative method to resolve medical liability disputes.

The AMA Fault-Based Liability Project is a proposed administrative alternative to the civil justice system for resolution of medical liability disputes. The model shares many characteristics of the worker's compensation system, and would be administered by state agencies and boards.

Anatomy of an ISMIE claim

Those who attended the "Anatomy of an ISMIE Claim" segment this year had an opportunity to see a mythical claim work its way through pretrial stages.

Those present gained insight on how a cooperative attitude can mean success at trial. They learned that even in a highly defensible case, the best of intentions might waiver in the face of a secure settlement offer. And they saw plainly how the ISMIE policy of litigating all defensible cases affects, and in a sense defines, the professional liability climate in Illinois. ▲



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* For some time now, we have been telling you that the Physicians' Benefits Trust (PBT) offers benefits programs that are "Just What the Doctors Ordered." That is because they are made to order for physicians. Remember, the PBT manages, on your behalf, the benefits programs sponsored by the Chicago Medical Society and the Illinois State Medical Society. In addition, our programs are endorsed by a number of county medical societies throughout Illinois.

To develop programs that are "Just What the Doctors Ordered," we began by asking doctors what they look for in insurance programs, both for personal protection and for their group practices. The study was conducted by an independent marketing research firm using focus group studies of physicians.

These physicians provided valuable insight into their needs and preferences. In addition, we continue to learn about physician preferences through your buying patterns for each of the plans we offer as well as in the comments and suggestions you make to us.

Once we gained a knowledge of your needs and preferences, we refined the existing programs to more accurately reflect your input. This was not as easy as it sounds, since we had to find insurance companies willing to meet your specific coverage requirements at low group rates. The results of our plan design and insurance negotiations is a program of benefits tailored specifically to the needs of physicians, their dependents and employees—all with the best overall rate structure in the state.

To administer the plans for PBT, your medical societies turned to the firm of R. T. Nelson & Associates, Ltd. This is one of the most prestigious insurance administration firms in the midwest with many years of experience serving the health care industry. The folks at Nelson manage your insurance programs, handle the delicate negotiations with the various insurance carriers and obtain for you the best coverage options and the best rates possible.

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For the Defense

A periodic column on matters of interest and relevance to the litigation process.

Stay calm. And work with your lawyer.

by Edward T. Butt, Jr., J.D.



Mr. Butt is a partner in the Chicago law firm of Wildman, Harrold, Allen & Dixon.

Much has been written about the emotional drain associated with participating in the legal system. Most of the stress is tied to the experience of watching an "alien" process evaluate your professional competence. But recently, a physician raised another point. The scheduling process used by the civil litigation system is not merely slow. It is also arcane, unpredictable and frustrating.

TIMOTHY FIELD, M.D. had agreed to testify as an expert witness supporting the defense of another physician. It was his first experience as an expert witness. Two years earlier, he had reviewed the file relating to the defendant's treatment and had expressed his opinion that the physician had not deviated from the applicable standard of care. As the suit wound its way through the court system and toward the time when it might actually go to trial (which in Chicago takes three to four years after suit is filed,* Dr. Field was told that plaintiff's attorney—as is his right—wanted to take Dr. Field's deposition to explore his opinions and the basis for them.

Dr. Field's deposition was scheduled and canceled five different times. One time it was even canceled after he had already left his office to travel downtown. Somehow with these postponements, trial was started without his deposition having been taken. Dr. Field is not sure exactly why or how. During trial, however, the court ordered that he be deposed during the trial beginning at 7:30 a.m. before court opened.** Eventually, Dr. Field did go on the stand and testify.

While I cannot condone the inconvenience experienced by Dr. Field, I can explain some of it and help you minimize the chance that you will be so greatly inconvenienced. The civil court system in Chicago and in all other large metropolitan areas is strained to the breaking point by litigation of all kinds. People who are owed money, people who seek to enforce contracts, and people who are injured have the right to seek redress in the courts. And because the number of interpersonal relationships (and hence interpersonal disputes) increase exponentially with the increase in people who live in congested proximity to each other, urban courts are overcrowded. Moreover,*** since 90-95 percent of these cases settle without trial, it is not economically efficient for the taxpayers to have an excess number of judges waiting to try cases. Thus (despite the myriad of attempts to create earlier, artificial bottlenecks), cases bottleneck at the actual time of trial.

Suddenly, however, there comes a time when all the parties and lawyers are available and the court system has an available judge. Then trial starts and everything changes. The case now involves innocent bystanders: jurors and witnesses. For the previous three to five years, the only people caught in the system have been almost exclusively the parties themselves, their lawyers, and other interested people (including compensated, expert witnesses). As a result, the flexible scheduling of the pretrial stage gives way to a rigid schedule at trial, a schedule enforced by a despot. During trial everything has to be coordinated and scheduled to take place in one room before the jury. Compare it, if you will, to surgery. Preoperative preparations can take place at various times, but once surgery begins, everything has to happen quickly and on schedule.

Lawyers have grown accustomed to being sent "out to trial," which for them means cancelling everything else previously scheduled, including expert witness depositions in other cases. Why then do lawyers schedule things when they might be sent out to trial? Because given the difficulty of having everybody ready at one time and having a judge available, and given that the vast majority of cases settle, an active trial lawyer would be setting aside all of his time for trials that never happen and never have time to prepare for them. Our judicial system is certainly not an efficient system, but it results in the fairest system available.

So how do you as an expert witness minimize these problems? First, keep in touch with the lawyer who retained you. Before you sit down to get ready for a scheduled deposition or possible trial date, call to assess the likelihood that things will go as scheduled. Have your office call again the day of the deposition and confirm that it will go; after all, the plaintiff's lawyer may have been ordered out to trial. Finally, when you agree on your compensation as a witness, make it clear up front that when some legal proceeding gets canceled on too short of notice to allow you to reschedule your practice, you will charge for the money you have actually lost. You will feel better if you have not been economically inconvenienced too.

Overall, Dr. Field still felt that his experience as an expert witness was nevertheless worthwhile. He wishes to pass on two pieces of advice, should you ever be in a similar situation. First, stay calm. If you are angry, you will be a poor witness and make a poor impression on the jury. Second, work with your lawyer. This person is going through the same chaos you are, but unlike you, he has been through it before.

**It is a long-standing joke that lawyers do not even bother to notify their witnesses of the first few trial dates because the chances of a trial actually starting then are infinitesimal.*
***It is my surmise that the judge felt that the defendant physician would probably win and wanted to bend over backwards in favor of plaintiff in his rulings so that an appeal would be less likely.*
****I used this word just so you would know I am a lawyer.*

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled these cases?

Case #1

Presenting complaint—Pain in woman's left breast

Subsequent diagnosis by another physician—Cancer of the breast with metastasis

The case in brief—A 52-year-old woman sought her physician's advice because she was experiencing pain in her left breast. The physician examined her and found a tender, firm mass at the outer border of the breast and ordered a mammogram. Findings proved suspicious. The physician saw the patient again a week later, advised her of the mammogram findings and told her she would need another mammogram. When a month had elapsed and the woman had not returned to the office, the physician sent her a certified letter emphasizing the need for close follow-up of her problem. The woman did make another appointment, but did not have another mammogram done before she returned to the physician's office. Upon a second examination the physician found no palpable lumps, but advised her to return in six weeks following another mammogram and to anticipate the need for a possible biopsy. Six months elapsed before the patient contacted the office again seeking medication for breast pain. An appointment was scheduled for her within a week. Again, she did not return. A month later, she saw another physician who diagnosed presence of an ovarian cyst and performed a hysterectomy and salpingo-oophorectomy. Ten days later she underwent a modified radical mastectomy and 10 of 15 lymph nodes were positive for cancer. She underwent cobalt treatment and no metastasis had occurred at the end of 18 months.

The resulting claim—The patient alleged that the first physician had failed to treat her breast malignancy.

The outcome of the claim—An indemnity of $205,000 was paid on behalf of the first physician.

Why problems arose with this case—The plaintiff's attorney contended that the initial treating physician should have performed a biopsy after the first suspicious mammogram was done. Cancer may have been present in the breast at the time the patient first made visits to the physician, but probably had not yet spread to the lymph nodes, the plaintiffs alleged. The plaintiff's lawyers argued that metastasis might have been prevented had the biopsy been performed, the presence of malignancy confirmed, and aggressive surgical or other intervention initiated. Even though the physician did make an effort to inform the patient by certified letter that it was very important that she return for further examination and that she have another mammogram done, the physician was vulnerable because there was no attempt at further follow-up care in the six months subsequent to her third visit.

The point this case makes—Meticulous follow-up of patients, especially those who may have serious and potentially life-threatening conditions, is essential to avoid liability.

—Once care has been initiated and a doctor-patient relationship established, it is incumbent upon the treat-

ing physician to assure proper follow-up.
—When a patient does not return at the scheduled or recommended interval to receive follow-up care, the physician must either advise the patient in writing of the importance of returning for further care or withdraw from the case, following the proper legal guidelines for doing so.
—Follow-up "tickler file" procedures should be instituted so that charts of patients requiring continuous care and periodic reexaminations are pulled on schedule and appointments made for them. Otherwise, such patients can "fall through the cracks" in the system, paving the way for potential problems.

Case #2

Presenting complaint—Red throat and high fever in 3-week old infant boy.

Subsequent diagnosis—Neonatal meningitis with sepsis.

The case in brief—On Day 1 the baby was brought to a family practitioner's office because he had a temperature of 102 degrees, a red throat, and was coughing. He refused to eat. The physician prescribed penicillin and told the mother to watch the baby closely. On Day 2 the baby was taken to a hospital emergency room where a physician on duty examined the infant, told the parents to continue the medication prescribed by the family doctor, but advised them to return to the hospital with the child if his condition changed. On Day 6 the parents took the child back to the family practitioner because his temperature now hovered around 104 degrees. The physician immediately diagnosed meningitis and/or pneumonia and admitted the child to a hospital for care. Soon after, the baby was transferred to an area neonatal intensive care unit. The child recovered but is now mentally handicapped, suffers seizures and has obstructive hydrocephalus.

The resulting claim—The parents alleged failure to diagnose meningitis.

The outcome of the claim—Total indemnity on behalf of the family physician and the hospital emergency room physician was $600,000, with the hospital ER physician responsible for $400,000 and the family practitioner for $200,000.

Why problems arose with this case—Delay in initiating aggressive treatment, confirming the diagnosis, ordering a sepsis work-up and chest-ray, poor follow-up and lack of communication between the two physicians all were factors leading to substantial liability. Both physicians' instructions to the parents to "watch" the child's conditions were too vague and this may have contributed to delay in diagnosis and treatment.

Failure to diagnose meningitis has been termed the second largest cause of malpractice cases against pediatricians by the American Academy of Pediatrics, which has formed a task force to address this problem. Whether the meningitis was present on Day 1 or Day 2 when the family physician and the hospital emergency room physician examined the baby cannot be determined with certainty, but because the child was so young and the fever so high, the cause of his illness should have been investigated more speedily.

The point this case makes–"Meningitis usually begins with upper respiratory and respiratory types of infection which progress through transient bacteremia, followed by meningitis after the bacteria are seeded in the meninges," according to John Dale Dunn, M.D., J.D., editor of an American College of Emergency Physicians risk management publication entitled "Foresight." Consequently:
—Physicians should consider a diagnosis of meningitis when evaluating febrile infants and watch for neurologic changes, behavioral changes and signs of toxicity.
—Systematic evaluation of such young patients, which might include a white blood count, blood cultures, urinalysis, examination of the external ear canal and other tests, also should include a spinal tap, but physicians should not wait for bacteriologic confirmation and spinal fluid analysis before beginning initial therapy if judgment suggests that meningitis is present.
—Close follow-up and repeat evaluations are advisable for infants and children with high fevers and even in patients with continued lower fevers. This requires that physicians instruct parents of such children specifically about what they should look for, such as respiratory distress, earaches, behavioral changes, neurological changes such as jitteriness or apathy, changes in color, skin, crying, general activity, nausea, vomiting, diarrhea, jaundice and fevers that spike even higher.
—Consultation with other physicians as needed in diagnosis and treatment is advisable. In this particular case, the family physician said he was unaware that the emergency room physician had seen the baby. Better communication between the two physicians might have led to faster diagnosis and treatment and prevented permanent disability, although it is not certain that the outcome could have been avoided. ▲

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REPORT FOR *Illinois Physicians*

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An asterisk indicates that the vendor offers an inexpensive "claims only system" whose only function is to submit your claims electronically. The system can be enhanced with practice management functions at a later date.

(This report is a service to the physicians of Illinois)
1/89

Health Care Quality Improvement Act: M.D. rights and duties

THE FEDERAL HEALTH CARE Quality Improvement Act was designed, its framers said, to curb medical malpractice and improve the quality of medical care. ISMS All Member Conference participants learned something about physician rights and responsibilities under the yet-untested legislation, and also its possible long-term effects.

Daniel D. Cowell, M.D., director of the Office of Quality Assurance, Bureau of Health Professions, U.S. Department of Health and Human Resources, opened the program. Interpretation and enforcement will fall within his sphere.

Dr. Cowell gave a general overview of the Act, illustrating with schematics (see diagrams at right). He announced that a contract for administrative services implementing the Act would be awarded very soon. The program "should be up and running by spring," he said.

Dr. Cowell stressed that his office is committed to equitable enforcement. The Office of Quality Assurance had been responsible for review of comments from interested parties, including ISMS. Final regulations were near completion. "When there was leeway," he said, "we interpreted for the sensitivity of practitioners and the needs of patients. It was a balancing act."

Finally, Dr. Cowell brought out a personal belief that state medical societies should renew their commitment to assistance for impaired physicians and other health professionals. Some have suggested that the reporting requirements may be a deterrent for impaired persons who should seek help, he said. "I hope that, as a byproduct of the Act, there will be increased concern for the impaired physician," he said.

Saul J. Morse, J.D., ISMS general counsel, examined physician rights and responsibilities, and the projected impact given current Illinois law.

"The Act is critical to ISMS members because it affects the rights and responsibilities of physicians involved in the peer review process in every setting," he said, "whether a hospital medical staff, an HMO or any other." Morse urged that physicians be sensitive to the implications of the national data bank, because the information it would contain and disseminate would clearly be used in hospital credentialing.

Morse reviewed the immunity provisions of the Act, described who is protected from civil liability and the prerequisites for obtaining immunity. He reminded the audience that there are no hard and fast rules for acceptable behavior in peer review or clear lines for immunity. However, he concluded, awareness of the stipulations defining full due process rights under the Act should provide immunity from civil damages for members of peer review bodies.

Morse pointed out a potentially troublesome requirement of the Act. The checklist of minimum due process hearing rights allows for peer review hearings before either: (a) an arbitrator mutually acceptable to health care entity and physician subject; (b) a hearing officer appointed by the entity who is not in direct economic competition with the physician; or (c) a panel of individuals appointed by the health care entity who are not in direct economic competition with the physician.

It has been ISMS policy that a majority of the members of the peer review committee be from the same specialty as the physician subject to the review. "In smaller communities," Morse said, "every physician who practices within a particular medical specialty can, and likely will, be considered to be an economic competitor. Therefore, the decision of who will make the peer review decision should be carefully watched by physicians to ensure both that the immunity provisions of the Act will be available and that the process is a fair one."

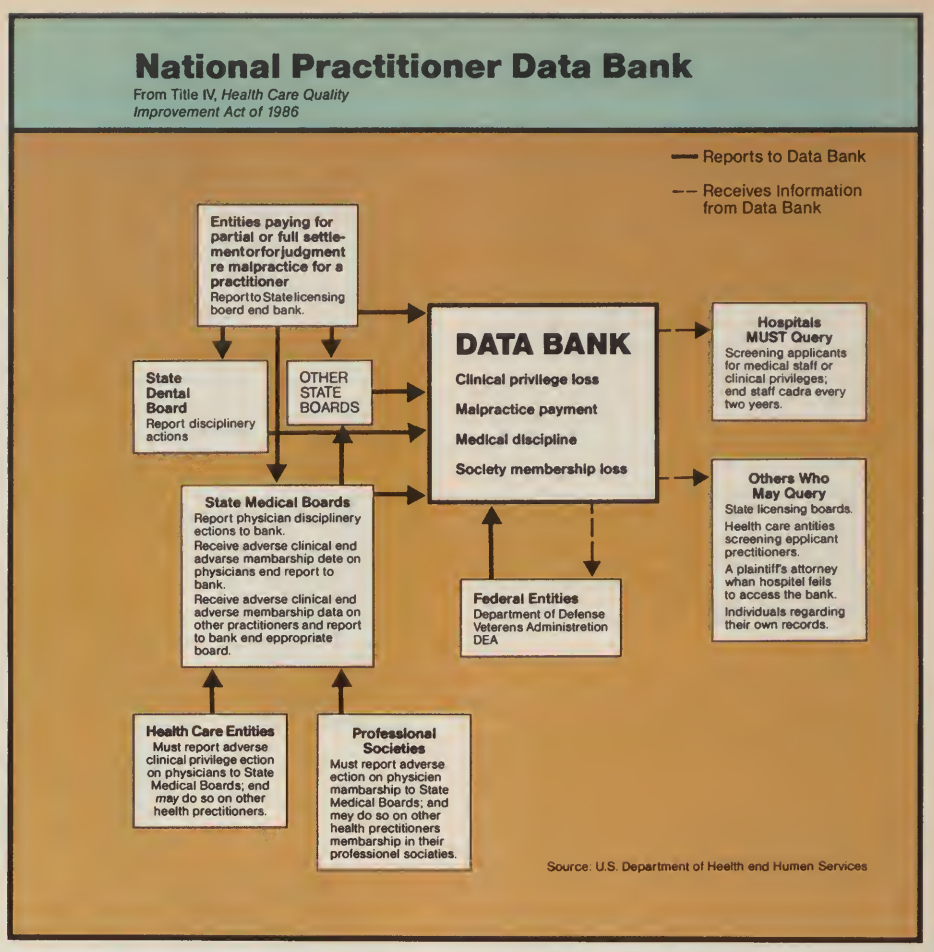
Morse reminded the audience that Illinois law already provides immunities from civil or criminal liability for good faith participation in peer review, and that mandatory reporting has been required in the state since 1983. He mentioned that hospital medical staffs need to be aware of some changes to medical staff bylaws that might be necessary as a result of the Act.

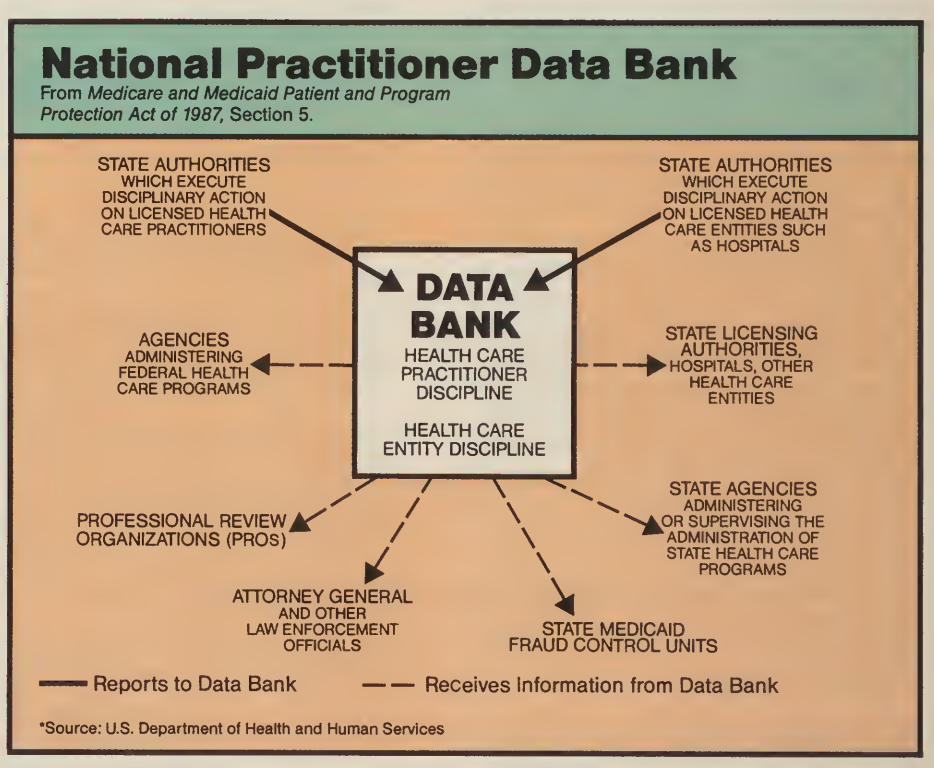
Finally, Frank J. McGarr, J.D., former senior judge, U.S. District Court for the Northern District of Illinois, considered background and likely long term effects of the legislation. Judge McGarr suggested that the Act would have lasting impact on the profession, and that ISMS should work to help direct the legislation as interpretation proceeds and amendments are developed.

"As Dr. Cowell applies the program, he will find gaps that Congress never thought of," McGarr said. He predicted that Congress would continue to amend the Act, but cautioned that no legislation could produce quality care. "That can only happen in the physician's office and in the hospital," he said.

McGarr described the Act as a reform bill designed to correct unintended consequences of earlier legislation. "No endeavor is free from government interference, and it is greatest in areas where government spends the most money," McGarr said. "The Health Care Quality Improvement Act plants the feet of government firmly in the profession, and this is not good for the physician-patient relationship. It harms the quality of care," he said.

McGarr told the audience that all the lobbying in the world will not change the situation, and what remained was an opportunity to fight a "rear-guard action" designed for damage control. Like the ISMS tort reform campaigns, McGarr said, those rear-guard actions are vital. ▲





These diagrams illustrate the flow of information and reporting requirements envisioned by the framers of the Health Care Quality Improvement Act. Information will be deposited to and accessed from the National Data Bank, which will be sole repository for required reports stipulated in the Act.

The Federal Health Care Quality Improvement Act What it means to Illinois physicians

Saul J. Morse, J.D., ISMS general counsel, offers these comments on some high-visibility concerns.

Q. What immunities does the Act provide?
A. No person who participates in a professional review action can be held liable for money damages under any state or federal law based upon the professional review action or their participation therein.

Q. Who is protected from civil liability under the Act?
A. The professional review body itself and its staff, as well as any person who provides information to the professional review body so long as certain minimum due process rights are afforded to the physician.

Q. What are the prerequisites for obtaining immunity from civil suit?
A. In order for physicians and hospitals to be entitled to the Act's immunity, the peer review or professional review action must be taken:

(continued on page 9)

What it means

(continued from page 8)

1. In the belief that the action was taken to further the quality of health care;
2. After effort has been made to obtain the facts;
3. After the physician against whom the action is contemplated is given notice of the action and a fair hearing or, at least the opportunity for a fair hearing should he (she) so desire; and
4. That the action taken was justified by the facts known.

Q. What is the minimum "due process" required by the Act in order for physicians and hospitals to be immune from civil suit?

A. The Act is fairly specific in the minimum due process rights to be afforded to the physician as part of the disciplinary hearing process:

1. Written notice of the proposed discipline;
2. Reasons for the proposed action;
3. Specification in the notice that the physician has 30 days in which to request hearing on the proposed action;
4. If a hearing is requested, a second notice must be sent to the physician stating the place, time and a date for the hearing of not less than 30 days after the notice, as well as a list of witnesses expected to testify at the hearing on behalf of the hospital;
5. If a hearing is requested, it must be held either before a mutually acceptable arbitrator or before a hearing officer or panel appointed by the hospital which is made up of persons who are not in direct economic competition with the physician involved;
6. The physician has the right to be represented by an attorney at the hearing;
7. The physician has the right to have a record made of the hearing; to call, examine and cross-examine witnesses and present relevant evidence at the hearing; and to submit a written statement at the close of the hearing; and
8. Upon completion of the hearing, the physician has the right to receive a written recommendation of the arbitrator or panel including a statement of the basis for that recommendation, as well as a written decision by the hospital which includes a statement of the basis for the decision.

Q. What information must be reported to the National Data Bank?

A. There are four areas that are required to be submitted:

1. Medical malpractice payments on behalf of physicians;
2. Discipline related to a physician's license by the Department of Professional Regulation;
3. Certain professional review actions taken by health care entities; and
4. Certain professional review actions taken by medical societies.

Q. Who must or may retrieve information from the National Data Bank?

A. The information reported to the Bank is to be considered strictly confidential and is not to be disclosed except as specifically provided for in the Act, and as specifically authorized by state law. Information from which the identification of the health care entity and physician has been deleted can be disclosed for research purposes. The Act requires that hospitals request information concerning physicians:

1. At the time the physician applies to be on the medical staff (courtesy or otherwise) or applies for clinical privileges at the hospital, and
2. Once every two years for physicians on the medical staff or those who have been granted clinical privileges at the hospital.

Physicians are permitted to request and receive information from the Bank about themselves. The Act also requires that the Secretary of HHS provide procedures for physicians to follow in the case of disputes regarding the accuracy of information.

The Act permits the State Department of Professional Regulation to access information contained in the Bank about particular physicians.

Health care entities, including HMOs, that have entered or may be entering into an employment or affiliation relationship with a physician or to which the physician has applied for clinical privileges or appointment to the medical staff may obtain information about that physician from the Bank. ▲

The following publications are essentially consonant with the Act and are available from ISMS:

"Physicians Guide to Due Process"
"Suggested Changes to Medical Staff Bylaws as a Result of the Health Care Quality Improvement Act of 1986"
"Health Care Quality Improvement Act of 1986: What Physicians Need to Know About the Act."

Inquiries may be directed to the Department of Educational and Medical Services: 1-312-782-1654; 1-800-782-ISMS. ▲

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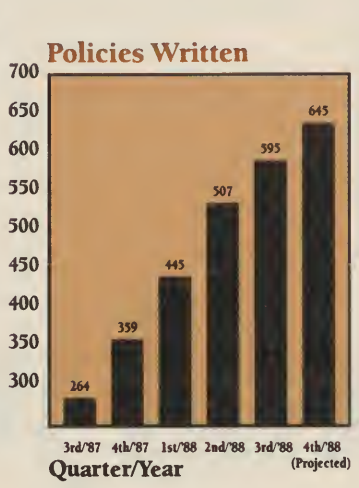
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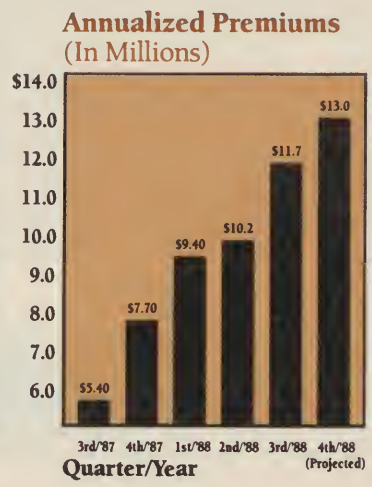
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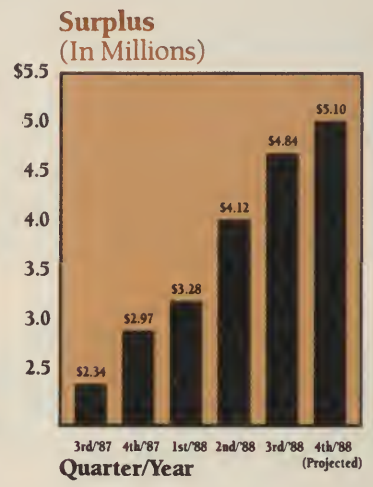
As we begin our third policy year of operation, I would like to say "thank you" to the policyholder/owners of Associated Physicians Insurance Company. Your intrepid support of APIC in its infancy is what made possible our emergence as the "other" physician-owned malpractice insurance company in Illinois.

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Today, we protect more than 600 physicians in every corner of Illinois and in virtually every clinical specialty. Each of you should be congratulated for believing in yourself and in your ability to create a viable professional liability insurance alternative. On a personal level, my involvement with APIC has provided the most satisfying experience of my 30+ years in the insurance business, and I thank you for the opportunity to be a part of APIC's success.

To Those Illinois Physicians Who Have Not Yet Joined Us...

We understand the caution that you have exercised by remaining with your current malpractice carrier. After all, your ability to practice medicine relies to some extent upon your insurance protection. That is exactly why the managers and directors of Associated Physicians have so diligently endeavored to deliver a professional liability alternative that addresses your most serious insurance questions.

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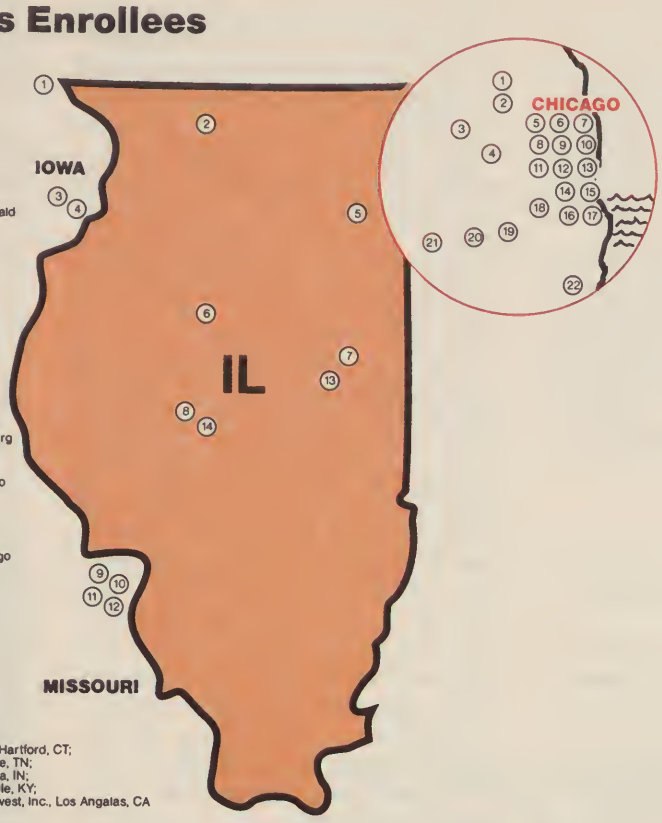
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ASSOCIATED PHYSICIANS INSURANCE COMPANY

HMOs with Illinois Enrollees

(As of June 30, 1988)



Outside Chicago area

1. Medical Associates Health Plan, Dubuque, IA
2. Clinicare, Rockford
3. Heritage National Healthplan, Inc., Davenport, IA
4. Quad-City Health Plan, Davanport, IA
5. Complete Health Care Corporation, Joliet
6. Health Plan of Central Illinois, Inc., Peoria
7. Carlecara, Inc., Urbana
8. Hospital Sistars HMO Corporation of Illinois, Springfield
9. Sanus Healthplan, Inc., St. Ann, MO
10. Group Health Plan, Inc., St. Louis, MO
11. Metlife Healthcara Network, Inc., St. Louis, MO
12. CIGNA Healthplan of St. Louis, Inc., St. Louis, MO
13. Personalcare HMO, Inc., Champaign
14. Professional Cara, Inc., Springfield

Chicago area

1. CIGNA Healthplan of Illinois, Inc., Des Plainas
2. Prudential Health Care Plan, Inc., Des Plainas
3. Metlife Healthcara Network of Illinois, Inc., Schaumburg
4. Share Health Plan of Illinois, Inc., Itasca
5. Access Health, Inc., Chicago
6. Anchor Organization for Health Maintanance, Chicago
7. Chicago HMO, Ltd., Chicago
8. Chicago HMO Plus, Ltd., Chicago
9. Compass Health Care Plans, Chicago
10. HMO Illinois, Inc., Chicago
11. Illinois Masonic Community Health Plan Corp., Chicago
12. Michael Reese Health Plan, Inc., Chicago
13. Mile Square Health Plan of Illinois, Chicago
14. Multicare, Inc., Chicago
15. Travelers Health Network of Illinois, Inc., Chicago
16. Union Health Service, Inc., Chicago
17. University of Illinois HMO Plan Trust, Chicago
18. Med Care, Maywood
19. Med Connect HMO of Illinois, Inc., Hinsdale
20. Healthchicago, Inc., Lisle
21. Dreyer HMO, Aurora
22. American Health Care Providers, Inc, Flossmoor

Not shown above are: Aetna Healthcara Programs, Inc., Hartford, CT; Equicor Health Plan, Inc., Nashville, TN; HMO Great Lakes, Inc., Fort Wayna, IN; Humana Health Plan, Inc., Louisville, KY; Maxicara Health Plans of the Midwest, Inc., Los Angalas, CA

Source of data: Illinois Department of Insurance

Illinois HMO Enrollment

(As of June 30, 1988)

HMO	*Enrollees*
HMO Illinois, Inc	281,118
Michael Reese Health Plan, Inc	157,470
Chicago HMO, Ltd	142,738
Anchor Organization for Health Maintenance	132,136
Maxicare Health Plans of the Midwest, Inc	122,474
Prudential Health Care Plan, Inc	121,433
Carlecare, Inc	93,464
Healthchicago, Inc	86,227
Share Health Plan of Illinois	56,721
HMO Great Lakes, Inc	51,573
Health Plan of Central Illinois, Inc	42,631
Heritage National Healthplan, Inc	41,946
Personalcare HMO, Inc	38,705
Hospital Sisters HMO Corp of Illinois	32,066
CIGNA Healthplan of Illinois, Inc	31,070
Med Care	29,299
Clinicare	27,671
Union Health Service, Inc	25,318
Sanus Health Plan, Inc	23,625
Dreyer HMO	19,341
American Health Care Providers, Inc	17,669
Multicare, Inc	17,058
Metlife Healthcare Network of Illinois, Inc	17,045
Professional Care, Inc	14,641
Aetna Healthcare Programs, Inc	12,527
Compass Health Care Plans	10,549
Group Health Plan, Inc	9,787
Access Health, Inc	7,662
Mile Square Health Plan of Illinois	5,701
Med Associates Health Plan	4,067
Humana Health Plan, Inc	3,716
Illinois Masonic Community Health Plan	2,177
Complete Health Care Corp	1,699
CIGNA Healthplan of St. Louis, Inc	1,533
Metlife Healthcare Network, Inc	758
Equicor Health Plan, Inc	85
Chicago HMO Plus, Ltd	0
Quad-City Health Plan	0
Travelers Health Network of Illinois, Inc	0

Figures unavailable for Med Connect HMO of Illinois, Inc, and University of Illinois HMO Plan Trust

Source of data: Illinois Department of Insurance

Illinois HMOs

(continued from page 1)



(L) Barry Averill, President of the Illinois Association of HMOs. (R) Joel Shalowitz, M.D., Director of Hospital and Health Services Management, Northwestern University, Evanston.

which is sponsored by Blue Cross/ Blue Shield.

Indeed, a study by Jurgovan and Blair, a Potomac, MD, consulting firm, concluded that 71% of all HMOs posted losses in 1986.

One reason for HMOs' recent deficits is the nature of the insurance cycle. "It is not unusual for the insurance industry to take big losses," said Averill. "The actuaries forecast what future costs are going to be, and if costs escalate faster [than expected], insurance companies wind up losing money. But then they start making adjustments, and in a few years, they run a surplus."

However, management and marketing problems also plague many HMOs. "An HMO is an unusual business," Averill conceded. "It is a combination of medical care and insurance; so you have to put in systems that will help contain the unnecessary use of services and to manage care in a way that maintains quality in a manner that is cost effective. Then you have to deal with the insurance pricing cycle to anticipate where costs are going to go and put in place good contracts with providers," he said.

"There are a whole series of variables that make [health care management] and pricing more difficult," Nicholson noted. For instance, "the cost and utilization of particular programs depend on the people who choose [to enroll in] the program. If a lot of older people choose a program, that will have an impact. If a lot of females of child-bearing years choose a program, that will have an impact."

According to Joel Shalowitz, M.D., director of hospital and health services management, Northwestern University, Evanston, some HMOs do not control utilization properly or they structure their plan poorly. "There are three things people want from a health care plan other than quality, which is a given. They want to pay as little as possible for health care premiums; they want first-dollar coverage; and they want complete freedom of choice. If you are going to control health care costs, you can't provide all three. But time and again, plans have been designed so they are all things to all people, and they have failed."

Other HMOs have made the mistake of contracting with as many physicians as possible, and "there are three problems with that," Dr. Shalowitz continued. "Number one, it is difficult to manage a system like that with all the information requirements and the need to contract with and monitor each physician. Number two, not every physician practices in a cost-effective manner. And number three, if you start to spread a fixed number of patients over a large number of physicians, each one will have a very small number of patients. When HMOs do not give physicians adequate numbers of patients to diversify their risk, physicians get burned, and there is a lot of ill will," he pointed out.

Finally, too many HMOs forget that health care is a local market. "Some HMOs fail because they do not realize that Chicago is a unique market, as is every other market in the country," Dr. Shalowitz said. "Local plan executives need to make local decisions about contracting [taking into consideration] what the marketplace is like. . . . HMOs also have to have about a 20,000-member population to break even. If you go to South Central Illinois, you need to cover a large area to get 20,000 people, and the geographic dispersion of these people makes it hard to deliver care." ▲

(Next issue: The Future for HMOs)

HMO market expected to grow: Analysts predict

Health maintenance organizations (HMOs) in the state of Illinois historically have attracted large multispecialty physician groups, such as Northwestern Memorial Hospital's medical faculty in Chicago and the Carle and Rockford Clinics downstate.

However, for many individual physicians, "there has not been a lot to gain by joining an HMO," said Fred Z. White, M.D., president of Health Plan of Central Illinois, a physician-sponsored independent practice association-model HMO with approximately 40,000 enrollees.

"The competition among doctors for patients has not been intense, particularly downstate, and patients have been paying their bills because the economy has been pretty good; so physicians have been able to get along quite well with just fee-for-service patients," he explained.

"Physicians who are practicing now, especially specialists, may not be seeing a lot of managed care cases and think that because they will not be paid 100 cents on the dollar [for treating these patients] involvement in an HMO is not worth their while," said Joel Shalowitz, M.D., director of hospital and health services management, Northwestern University, Evanston.

However, some observers believe that the HMO market will expand greatly over the next 10 years. Kenneth S. Abramowitz, health care analyst with Sanford C. Bernstein and Co., Inc., NY, has predicted that growth among private pay patients will drop significantly for the fee-for-service sector, down from 89% in 1984 to 10% in 1997. In contrast, he suggests that the HMO sector will grow by 43%, capturing 50% of private pay patients by 1997.

David Glaser, a research analyst for Minnesota's Interstudy, a nonprofit think tank which studies developments in health care delivery and financing, has no specific projection. But he did shed light on the underlying rationale.

"In the short run, you may see an increasing number of employers drawn to PPOs because they offer free choice with built-in cost containment," he said. "In the long term, as employers seek additional cost containment, and employees become more comfortable with managed care, HMO and HMO hybrids will see additional enrollment growth." ▲

Illinois residents

(continued from page 1)

"The objective of this meeting is to identify as many of the problems as we can on both sides, and then develop a strategy for addressing those problems," Dr. Pochyly said.

Prior to the seminar, the Department of Professional Regulation had reprimanded some residents who had started training before receiving temporary licenses. The Department had also announced that residency program directors could be held personally "culpable" for permitting the unlicensed practice of medicine. In addition, the Department had warned that residents who moonlighted on a temporary license outside their programs were practicing medicine illegally.

After introducing members of the Department's Medical Licensing Board (MLB), Dr. Pochyly called on Stephen F. Selcke, Director of the Department of Professional Regulation, and ISMS Board of Trustees Chairman Harold L. Jensen, M.D. "Our department is pleased to cosponsor this seminar with the Illinois State Medical Society to talk about some of the provisions and requirements of the Medical Practice Act," Director Selcke said. "We hope to help inform you about what your responsibilities are under the Act."

Dr. Jensen spoke to the partnership between professional societies and residency directors. "The Illinois State Medical Society and the residency program directors both play an important role in the present and future health care environment," Dr. Jensen said. "ISMS is medicine's advocate in the General Assembly and the state regulatory agencies, such as our host today, the Department of Professional Regulation. You directors provide quality training for our physicians, present and future, and an important role it is too. We two groups may function apart, but we do not function separately." Dr. Jensen also noted that ISMS surveys of residents and young physicians revealed a concern by these groups that they need more information on economic and other practice-related issues—two areas where ISMS can assist residency programs.

Residents have been known to begin training prior to receiving their temporary licenses, which is "explicitly not supported by the law."

Michael Accetura, general counsel for the Department of Professional Regulation, and Maureen Mulhall, the Department's administrator of the Medical Practice Act, were present to explain the licensure application process and clarify provisions of the Act relating to temporary licensure. Joining them to provide insight from the Medical Licensing Board's viewpoint was Lawrence L. Hirsch, M.D., chairman.

The seminar covered such topics as required documentation for license applications, amendments to the Act relating to pre-1985 medical school graduates and disciplinary policies regarding residents and residency programs.

Changes in Medical Practice Act

Sunset provisions mandated by the General Assembly in 1979 provided for the review of the original 1923 Medical Practice Act. The current Medical Practice Act, containing substantive changes, was signed into law by Governor Thompson in May 1987 and became effective on January 1, 1988. Amendments clarifying the status of pre-1985 medical graduates were passed in the last session of the General Assembly and signed into law last summer. Final regulations implementing the Act should be out within a few weeks.

All applicants for permanent licensure must now complete two years of post-graduate clinical training. (Formerly, only one year of residency training was required.) There is no distinction between graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) and schools not approved by LCME, or between graduates of United States and foreign medical schools. The state no longer approves medical programs. All applicants are judged on the same educational criteria. However, it was noted that information from foreign medical schools is often difficult or impossible to obtain, necessitating a closer examination of graduates of those programs.

Moonlighting

"The law has to my knowledge always been that you must have a license to be in a residency program, and [that] moonlighting is prohibited without permanent licensure," said Mulhall.

Many attendees had questions regarding the Department's definition of the "unlicensed practice of medicine" and what constitutes "moonlighting," as well as their obligations in such cases.

Mulhall said that residents have been known to begin training prior to receiving their temporary licenses, which is "explicitly not supported by the law." Often, Mulhall said, such residents defended their actions, saying they had been advised that failure to begin training on the contractually specified date could result in forfeiture of the appointment.

Mulhall said that, in such instances, it will be Department policy to "look up the facility's chain of command for the official who is responsible for putting that person to work without a license, and hold the official culpable, along with the resident who has gone to work without a license."

Mulhall also advised residency program directors to consult their legal departments when drafting contracts for prospective residents to ensure that their obligations to the residents are also in compliance with the law.

Similarly, Mulhall cautioned that temporary licenses are only valid for specific programs. For example, surgery residents who may be "moonlighting" in another program, such as pediatrics, are in violation of the law.

Also, if residents are required to assume additional responsibility in their residency program, for which they may or may not be compensated, those duties must fall "within the confines of their residency program" and should be specified in the contract, according to the panel.

"You define the residency program with that individual generally by contract, we don't," Accetura said. "You might want to consider amending your contract if you impose additional duties on the individual. If they had 15 things to do and now they have 17, you might want to amend your contract or protocols."

Procedures and criteria for application

Because the Department of Professional Regulation is charged with licensing individuals and not residency training programs, the onus is on the applicant to ensure that all relevant documentation supporting a license application is submitted to the Department.

Nevertheless, Department representatives cited several actions that residency program directors can take to facilitate the license application process, and help ensure that prospective residents comply with the law.

State law requires that temporary license applications are due 60 days prior to the beginning of a residency program (*e.g.,* May 1 for a July 1 residency). Accetura said that the Department receives 90 percent of its applications after the deadline.

State law requires that temporary license applications are due 60 days prior to the beginning of a residency program . . . the Department receives 90 percent of its applications after the deadline.

The Department still processes applications received after May 1, and temporary license applications receive priority over permanent license applications during the peak period of May to June when additional staff are hired to process applications, spokesmen said. However, the later the application the more difficult it is to guarantee issuance of a temporary license by July 1. Attendees were advised to encourage that prospective residents file their applications as soon as possible following their selection for a program.

Incomplete files are the principal reason for delay, Accetura said. These most often result when multiple sources submit documents separately. Residency program directors who can ensure that an application containing all required documents is submitted in one package will help facilitate the process. The Department indicated that most applications do not require a review by the MLB, which examines only those cases falling outside the normal criteria.

Applicants who cannot successfully document that the two year clinical core rotation training was performed in a program formally affiliated with their medical school will also be delayed. These must be reviewed by the MLB. In addition, applicants who affirmatively answer questions regarding personal history (*e.g.,* prior felony convictions, previous license revocation, past drug or alcohol abuse), will likewise have their applications reviewed by the MLB. Finally, such bureaucratic snags as name changes, or hyphenated names not consistently listed on all documents can further delay the process.

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The ISMS Board of Trustees met in Springfield on November 4. While full minutes are available to any member upon request, these synopses provide a brief overview.

ISMS WILL NOT pursue legislation to participate in the federal Health Care Quality Improvement Act prior to its October 1989 implementation date. Physician rights and responsibilities are examined in documents ISMS will distribute to the county medical societies and hospital medical staff leadership.

AN ISMS PHYSICIAN placement information clearinghouse for residents and newcomers will be up and running in a few months, providing ready access to resources and support systems for job seekers.

AIDS AND ATHLETICS will be the subject for an educational brochure planned as part of the continuing adolescent health effort.

ILLINOIS DEPARTMENT OF Professional Regulation Director Stephen Selcke reports: The Department has increased its medical disciplinary investigative staff from 14 to 32 persons as a result of the new Medical Practice Act. . . . The 31,000 medical licenses granted by the Department include about 25,000 physicians who work and/or live in Illinois. . . . 625 complaints against physicians were investigated in 1987. . . . Over 700 Illinois medical licenses expired on July 31 without renewal (physicians practicing medicine without a current license are subject to disciplinary action.)

THE ILLINOIS DEPARTMENT of Public Health will distribute an ISMS brochure, "AIDS: Facts for Physicians," which provides information on the physicians' legal responsibilities under Illinois AIDS laws. ▲

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Illinois Medicine

January 20, 1989 ILLINOIS STATE MEDICAL SOCIETY

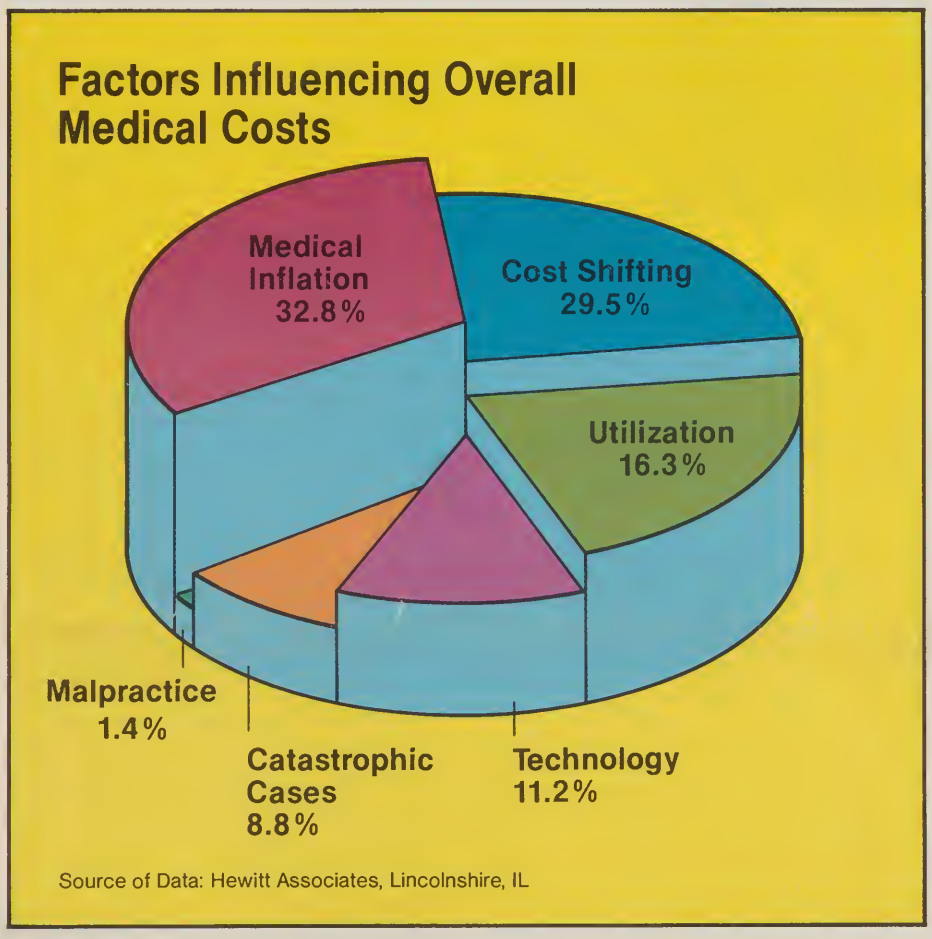
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Health benefits costs to soar more

Insurers, employers differ on range, but most are near 20%; North Central states expected to meet—or exceed—national averages

by Karen Sandrick

ALTHOUGH ESTIMATES VARY, insurers and employers agree that health insurance rates will rise in double digits in 1989 because of expected increases in health benefits costs. Insurance industry observers believe that Illinois employers will see increases comparable to those projected for the nation as a whole. However, they predict that because of a slightly higher rate of inflation in the Midwest and greater cost shifting, Illinois insurers will seek increases greater than national averages.



Health insurers

Major U.S. health insurance carriers predict large increases in the cost of health benefits covered by indemnity plans because of so-called medical trends. Medical trends are insurance carriers' best guess of the effect various cost factors will have on overall medical costs.

Two employer benefits consulting firms report a medical trend factor of about 22 percent for 1989. Noble Lowndes, an East Orange, NJ-based actuarial and employer benefits consulting firm serving 5000 clients worldwide, has not yet firmed up its 1989 trend projections. Nonetheless, its preliminary findings indicate that insurers' nationwide trend factor will be between 21 and 22 percent.

This trend forecast is based on "information gathered from all over the country on factors that influence the rate at which medical benefit costs will increase in the year ahead," says David L. Brenneman, vice-president.

For example, Noble Lowndes analyzes:

- medical inflation, including hospital room and board, ancillary and outpatient service charges, prescription drugs, and physician services;
- leveraging, or the increase in medical claims costs that arises because of the difference between medical inflation and fixed medical plan benefits;
- cost shifting, or the transfer to private payers of costs that are not paid by public payers, charity patients and self-pay patients;
- antiselection, which reflects benefit cost increases from federal legislation requiring that benefits be paid to terminated or other "ineligible" employees;
- technology, or the increased cost of delivering services with technologically advanced equipment or procedures; and
- utilization, or increased utilization as a result of an aging population and increased availability of health services.

Hewitt Associates of Lincolnshire, Illinois, an international firm of consultants and actuaries that specializes in the design, financing, and administration of employee benefit and compensation programs, reports that the medical trend will be between 17 and 23 percent in 1989.

Hewitt's trend forecast is based on a survey of four major national insurers and the insurers' own projections of the effects of medical inflation, cost shifting, utilization, new technology, high-cost catastrophic claims, and malpractice.

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Physician recruitment: both an art and a science

AN ILLINOIS MEDICINE SPECIAL REPORT
Illinois' MD Shortage

by David H. Cohen

MATCHING PHYSICIAN and community is a delicate balance of mathematics and geography tempered by equally important personal factors. Numbers tied to compensation, patient base, subspecialty consults and miles to the nearest hospital draw an early bottom line. Softer factors, such as a rural background—or a spouse's rural background—can make or break a physician-community "match."

Location choice begins with the hard data. "Every physician requires a certain number of patients to successfully launch and maintain his practice," said Fred Wellhausen, a physician recruiter for 17 years. "For instance, a family practice physician would need a population of 3,000. If he or she moves into a small city of 1,000, you can rest assured that the outlying marketing area would have an additional 6,000 to 7,000 people. If you have a marketing area of 10,000 and only two other family physicians, you can be assured of a successful practice."

Much depends upon specialty. According to Wellhausen, an allergist needs a 25,000 marketing area; a neurosurgical practice requires a population base of 100,000.

Wellhausen defines the "marketing area," as a 10-mile radius in a rural setting; other factors apply in urban areas. Wellhausen's second geographic restriction is the hospital distance—more than 25-30 miles, he

(continued on page 5)



Moonlighting Medics?

Physician leaders of the Illinois State Medical Society, Illinois State Medical Inter-Insurance Exchange and Illinois State Medical Insurance Services, Inc., at formal groundbreaking ceremony for new ISMS Springfield office on November 4, 1988. The new ISMS Springfield office at 600 S. Second St., Springfield, will be a four story building with space for tenants. Shown above (L-R) are Harold L. Jensen, M.D., Harvey, chairman, ISMS Board of Trustees, Eugene P. Johnson, M.D., Casey, ISMS president-elect, Fred Z. White, M.D., chairman, ISMIE Board of Governors, Harry A. Springer, M.D., Evanston, ISMS president and Robert C. Hamilton, M.D., Chicago, chairman, ISMIS Board of Directors.

Minimum employee health insurance benefits proposed

STATE SEN. HOWARD CARROLL (D-Chicago) and State Rep. John Cullerton (D-Chicago) announced last week that they will sponsor legislation designed to address what they termed "a health care accessibility crisis of monstrous proportions," in Illinois.

The proposal, requiring that Illinois employers with more than five workers provide a package of minimum health insurance benefits, embodies recommendations made by the Illinois Hospital Association (IHA) as part of a larger plan, dubbed ACT—Accessible Care Today.

According to Sen. Carroll, the proposal responds to a recent spate of Illinois hospital closings which have been most often tied to undercompensation for Medicaid and Medicare services. "Of comparable significance and enormous cost is the almost $600 million annually in totally uncompensated care provided by Illinois hospitals to those individuals who make too much to be classified poor, yet don't have enough to pay their own way," he said. "They have neither Medicaid, Medicare nor health insurance, and the ranks of these working poor are swelling."

Sen. Carroll said that the legislation would cover nearly half of the estimated 1.5 million Illinois citizens who have no health insurance coverage. IHA estimates that the plan would provide benefits to more than 600,000 working Illinois residents and another 90,000 receiving unemployment compensation. (Those already covered by spouse or dependent health insurance would not be required to participate.)

IHA President Kenneth Robbins, who joined the legislators in announcing the proposal, stressed that it was not a total solution. "The other half of Illinois' uninsured citizens, including a substantial number of women and children who do not qualify for Medicaid or Medicare, would continue to be serviced by hospitals, with their care being subsidized by these institutions," he said. "The uncompensated care proposal is a start, not a panacea."

Sen. Carroll and Rep. Cullerton outlined basic criteria of the plan, although they stressed that the details are not final. Employers with more than five workers would be required to provide minimum indemnity health coverage to include inpatient and outpatient hospital care, physician care and some other services, or its actuarial equivalent. Employees would pay a $500 calendar year deductible and 20% copayment for health care, with maximum out-of-pocket cost of $1,000 beyond the deductible.

A private sector multi-employer trust would be established to offer the minimum benefit package, at an estimated cost of $86 per person per month. Employers would be responsible for 80% of that and employees for the balance. IHA estimates about 610,000 Illinois citizens would be covered, at a total private sector employer cost of $428.3 million.

Employers who decline to participate would be subject to a per-employee tax of 110% of the employer premium cost. Those taxes would be earmarked for Medicaid payments to hospitals providing care to a disproportionate share of indigent patients. Such payments are eligible for federal matching funds. Finally, a percentage of the premiums would go to a special fund to provide an identical package to persons collecting unemployment compensation, whose payment portion would be defined by their level of unemployment compensation.

Sen. Carroll and Rep. Cullerton said that the plan was not yet sufficiently firm to take the form of an actual bill. ▲

Contracting service update

THE ILLINOIS STATE Medical Society (ISMS) has revised membership services in alternative delivery system contracts. Contract reviews offered by the ISMS Office of Contractual Services ceased as of January 1, as ISMS brought new emphasis to member education.

ISMS General Counsel Saul J. Morse will supervise a series of seminars across the state on contracting issues. The Society will develop a manual for physicians seeking to evaluate alternatives. ISMS also plans to compile a roster of attorneys who specialize in contracting issues and who are willing to provide quality representation at a reasonable fee.

Morse explained that as alternative delivery systems contracts become more complex and sophisticated, the need for physician education becomes more important. "It is our hope that the seminars and manual will serve as informational and educational tools, to make the physician's decision-making process a more positive one," he said.

The Society's services in this area are strictly educational. ISMS can neither provide legal counsel to individual members nor negotiate contracts. The physician must make his or her own decision to seek, and then select, legal counsel. These matters are the exclusive responsibility of the individual, and will not in any way involve ISMS.

"It is hoped that this service will assist physicians in making certain that those representing them are skilled in these critical areas," Morse said. "The decision as to whether to hire an attorney and, if so, who that attorney will be, is left exclusively up to the individual physician."

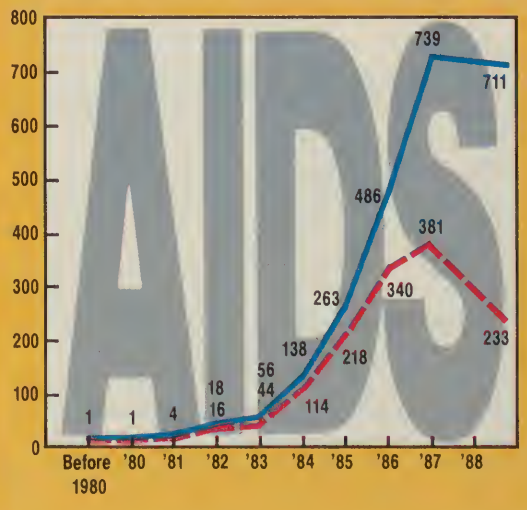
The ISMS seminars will be supplemented by tailored programs conducted for a reasonable fee by attorneys working with ISMS. County medical societies, hospital staffs or group practices may request programs designed to meet their specific needs.

Members interested in scheduling a seminar or seeking more information on the program may contact Mr. Morse directly at Morse, Giganti and Appleton, 828 S. Second, #102, Springfield 62708; (217-523-1888).

Physician Facts

Reported AIDS Cases and Case-Fatality Rates in Illinois

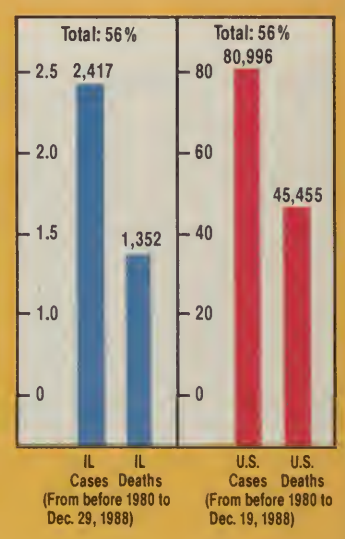
(Cases Which Have Met the CDC Definition of AIDS)



Source of Data: Illinois Department of Public Health year-end 1988 figures

Comparison of Illinois and U.S. Case-Fatality Rates

(In Thousands)



Source of Data: Illinois Department of Public Health year-end 1988 figures and U.S. Centers for Disease Control, Dec. 19, 1988 figures

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Health Insurance

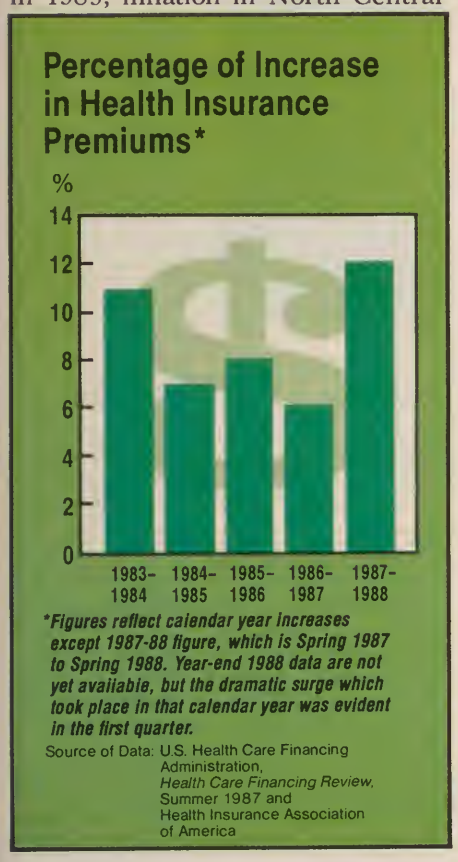
(continued from page 1)

Medical trends in Illinois may be slightly higher then national trend estimates.

A survey of 20 insurance carriers in Illinois disclosed that medical trends rose steadily here last year, beginning with a 19.28 percent trend for the first quarter of 1988, 20.38 percent for the second quarter, and 21.48 percent for the third quarter.

Some Illinois health insurers have cited trends in excess of 22 percent for 1989. Northwest National Insurance Company's trend, as of January 1, was slated to be 27 percent, and Cigna's trend was upped to 24 percent from 22 percent on November 1, according to Tony Herron, senior consultant in the Chicago office of Noble Lowndes.

Noble Lowndes' national spokesman Brenneman predicts that medical inflation in the North Central part of the country will exceed the national average. Preliminary figures suggest that while the national medical inflation rate will be 9.2 percent in 1989, inflation in North Central



Figures reflect calendar year increases except 1987-88 figure, which is Spring 1987 to Spring 1988. Year-end 1988 data are not yet available, but the dramatic surge which took place in that calendar year was evident in the first quarter.

Source of Data: U.S. Health Care Financing Administration, *Health Care Financing Review*, Summer 1987 and Health Insurance Association of America

states will be 10.1 percent.

He also suggests that as a result of higher inflation, the North Central United States will have a greater leveraging effect (2.5 percent in this region as opposed to 2.3 percent nationally).

Employers

Employers expect that their health benefits costs will rise in 1989 but not as high as insurers indicate. A. Foster Higgins and Co., Inc., New York City, the employee benefits consulting division of Johnson and Higgins and Co., Inc., produces each year the Health Care Benefits Survey, which comprehensively analyzes employers' benefits programs and cost management issues.

The 1988 survey, which will be released sometime this month, shows that employers' projected total health plan costs per employee were 18.6 percent higher than 1987, and estimates for 1989 are similar, says Pamela J. Blake, manager of health surveys for Foster Higgins.

The 1988 survey obtained information from 1633 employers of all sizes—from a total of two employees to 130,000 employees—in the public and private sectors in all 50 states. Employers' projections for all administrative and claims costs (including medical, dental, prescription drugs, vision, hearing, and HMOs) for employers and dependents averaged out to $2312 per employee for employers who purchase coverage and $2408 for self-insured companies.

Illinois employers have similar estimates. Steve MacGill, consultant with Foster Higgins, Chicago, notes that "from our own clients, we are seeing somewhere in the neighborhood of 18 to 19 percent increases when we look at real live claims data projected forward to 1989."

What does it all mean?

What will health insurance rate increases be in 1989—22 percent or more as health insurers indicate or 18 percent as employers expect? Opinion is mixed.

Larry Berry of the Illinois Health and Life Insurance Council points out that with medical trend factors at 22 percent, "right off the bat we're starting with a high figure. And that doesn't include group experience."

As Arnold Dutcher, examiner with the Illinois Department of Insurance, notes, medical trend factors are only part of the picture; premiums also are experience related. "If a group had a particularly bad experience, its rates will increase more than groups that did not have a bad experience."

Noble Lowndes' Brenneman believes that actual insurance premiums will increase 27 to 32 percent not only to account for medical trends but also to cover 1988 expenses. "Insurers underestimated trends in 1988, and their reserves are at unacceptably low levels; so they will be playing catch-up in 1989."

However, John Gable of the Health Insurance Association of America, Washington, DC, contends that actual rate increases will not be as high as 20 percent. "Those rates are what the insurance companies hope to get rather than what they do get," he said. After all, he says, "employers do shop around, and they will leave one insurer for another if they are faced with a 30 percent increase."

Health insurers will be announcing their premium hikes in the next few weeks. And whether the increases turn out to be 18 percent or 20+ percent, it's not going to be good news. ▲

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

SPECIAL NOTICE—APPEALS PROCESS

The purpose of this notice is to inform you of certain procedural revisions recently received from the Health Care Financing Administration, and to remind you of your appeal rights under Part B of the Medicare Program.

Part B Carrier Appeals

As a physician or supplier providing items and services to Medicare beneficiaries payable under Part B, you may appeal an initial determination if you:

- Accepted assignment;
- Did not accept assignment and we denied the claim as not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the services would not be covered, requiring you to return any money you had collected for these services; or
- You are the duly authorized representative of the beneficiary.

If you are dissatisfied with the carrier's initial determination and the determination is subject to appeal, you may request a review. The request must be in writing, signed, and filed within 6 months following the date of the initial determination.

If you remain dissatisfied after the review determination, and the amount in controversy is at least $100, you may request a fair hearing: in person, by telephone, or based on-the-record. Requests for fair hearings must be filed, in writing, within 6 months following the date of the review determination.

If you are still dissatisfied with the determination made by the hearing officer, and the amount in controversy is at least $500, you may request a hearing before an Administrative Law Judge of the Social Security Administration. The request must be in writing and filed within 60 days of the date of the fair hearing decision of record. Finally, if you are still dissatisfied, and the amount in controversy is at least $1,000, you may seek judicial review.

Development of Appeals

For individual claims submitted by providers, physicians, and others who furnish items and services to Medicare beneficiaries, the responsibility of gathering and submitting documentation that supports claims and appeals rests with the provider. We will offer guidance and assistance as necessary, but the responsibility for identifying what is needed and where it is located is your responsibility. If you have tried to secure essential documentation, but have been unsuccessful, we will try to assist you.

Reopenings

Reopenings are not, in a legal sense, appeals. They are actions (taken after a claim is closed) to correct an error in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed. Reopenings should be done rarely, on individual cases, or on a group of cases adversely affected by a systems error.

Usually, these reopenings occur because claimants fail to submit supporting documentation on a timely basis. The timely submittal of documentation negates the perceived need for "reopening", and helps to ensure timely payment.

CPT/HCPCS CODING INFORMATION—REMINDER

As you know, CPT/HCPCS is a national coding system for reporting physician/supplier services under the Medicare Program. The CPT/HCPCS coding system provides the most up-to-date set of codes available.

The 1989 version of CPT is available for purchase from the American Medical Association. The HCPCS Coding Manual is available free of charge by writing to Medicare B, Freedom of Information Unit, P.O. Box 992, Marion, Illinois 62959 (this manual is updated annually). The 2 manuals together provide you with a complete set of codes. With CPT-4/HCPCS most services can be billed by using the procedure code *only*. No narrative description is needed when an accurate code is provided on your claim, thus making less work for your billing personnel.

Finally, CPT/HCPCS provides a common terminology for communicating with medicare carriers nationwide or other physicians/suppliers, about Medicare claims and/or coverage issues.

(This report is a service to the physicians of Illinois)
1/20/89

Editorials

On "can do" and all that

There's been a great deal of talk about the physician shortage in rural Illinois. This issue's physician recruitment story shows that those concerns are valid. Recent headlines about hospital closings and obstetric care shortages support the contention that physician supply is a serious problem that isn't going away.

The good news is that Illinois' medical leadership was ready to do more than hand-wringing on this before the need was so immediate. The Illinois State Medical Society/Illinois Agricultural Association (ISMS/IAA) Medical Student Loan Fund project celebrates its fortieth anniversary this spring.

The ISMS/IAA Medical Student Loan Fund was a creative solution generated by a few open-minded, can-do types. People who believed in attacking a problem head-on came out of the huddle smiling. Their plan succeeded, and for forty years, it's continued to succeed.

This issue of *Illinois Medicine* encloses the Society's Annual Report, a litany of what can-do types can do when they collaborate. Professional associations may not be able to solve the physician shortage problem, or quell the medical liability crisis or resolve the dilemma of medical indigency. But they have a head start.

Consider the source

The role of the expert witness in a medical malpractice trial is a continuing concern. Stories about professional experts, inexpert experts and unscrupulous experts abound.

The medical expert is essential to a malpractice trial. He or she sets the standard against which the defendant physician will be measured. Jurors depend on the expert witness to provide a context for their deliberations.

As a result of the 1985 professional liabilty initiative, Illinois law requires that expert witnesses share the defendant's specialty and also devote a substantial portion of time to practice or study in the area at issue.

The recent Illinois Supreme Court decision in *Trower* vs. *Jones* is good news for doctors and their patients. Jurors have the right to know, the Court said, if the expert witness may be more expert in the art of testifying than in the medical specialty at hand. And they should also be told, the Court said, when a witness only testifies for plaintiffs or defendants.

In sum, Illinois jurors are now better equipped to assess the credibility of the expert witness. On balance, when people have more information, they make better decisions. Illinois juries will now know whether the opinion they hear comes from a professional truly expert and practicing in the field or a "hired gun" who testifies well. It's a sure-footed step toward better-informed juries and a better climate for the profession in Illinois. ▲

Illinois Medicine

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President's Column

Unique and necessary



Harry A. Springer, M.D.

"I'M DOING SOMETHING I never thought I would do", said Uwe Reinhardt, Ph.D., health care economist and luncheon speaker at the ISMS All Member Conference in Springfield on November 5, 1988. "I'm lobbying on behalf of the AMA. Stick with them."

Reinhardt was talking about how physicians of all specialties have to stick together in the face of the resource-based relative value scales proposed for Medicare reimbursement. And he was admitting there was a need and a place for an association to represent physicians.

Alexis de Tocqueville, traveling in America in 1830, wrote, "Americans of all ages, all stations of life, and all types of dispositions are forever forming associations." It is unique to America and Americans that they band together, not because they have to, but because they want to, in order to accomplish something which individuals cannot accomplish alone. It is unique to America and Americans that citizens do this, outside the governmental structure, in a voluntary, self-governing fashion. Associations serve as the training ground for self-governance.

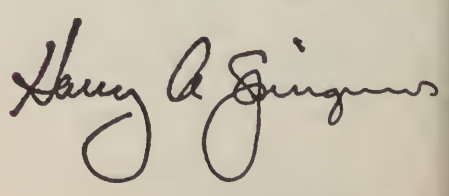
Your county medical society, the Illinois State Medical Society and the American Medical Association are voluntary associations formed to achieve objectives and goals and to derive benefits and services for physicians and their patients. Each level of organized medicine—county, state, national—is unique and necessary. If these were suddenly to disappear, physicians would immediately replace them. This is because medical societies fill needs that aren't being filled elsewhere.

Sometimes we take our medical society for granted, assuming it will be there doing the thousand invisible tasks and performing the myriad of services that make up a day's work in an association. In my tenure as President, I have worked with committees, boards, councils, other state associations, government leaders, regulatory and agency heads, county medical societies and hospital medical staffs, to solve the problems of physicians and their patients. Take my word for it, there are hundreds of physicians and staff members who are working every day on your behalf.

Sometimes we grumble about paying dues. As a physician who has witnessed first hand the workings of all three levels of organized medicine, I can say that physicians in Illinois are getting high value for their dues dollar. This month, you will receive a 1989 dues bill. Many members have already paid and to those prompt and reliable members, we say thank you. To those of you who haven't, we hope to receive your dues soon.

The 1988 ISMS Annual Report is enclosed with this issue of *Illinois Medicine*. It gives highlights of what was accomplished by ISMS in 1988. It does not attempt, nor could one annual report succeed, in telling the story of what ISMS does for its members 365 days a year. Please read it. Share it with another physician who may not be a member. Place it in your waiting room along with *Illinois Medicine* so your patients know what your state society is doing for them.

Without associations, we Americans wouldn't have the force, experience, training and skills to govern ourselves and get things done. Associating is the American way. ▲



Harry A. Springer, M.D.
President
Illinois State Medical Society

Physician Recruitment

(continued from page 1)

says, and recruitment becomes difficult. A one-hour drive to the hospital each way, Wellhausen notes, means that an hour's rounds will occupy half the work day and leave little time to see other patients.

Bill Adkisson, a medical recruiter in Bloomington, says urban areas like Chicago, Peoria, Springfield, Bloomington, Decatur, and Champaign-Urbana are still able to recruit physicians, but hospitals in the smaller towns bear a major handicap. In some cases, the retirement of the "town doctor," is a crisis for the community.

"A small town like Industry, Illinois, in the western part of the state with a population under 800 will pay a recruiter to find a physician," says Adkisson. "But the probability of their finding one is under one percent. Few doctors want to be in a small town and be on call 24 hours a day, seven days a week."

Restrictions on government spending and a severe squeeze on obstetrical services in rural Illinois have made acquiring the right medical talent a life and death affair for hospitals across the state.

Since the advent of Diagnosis Related Groups in 1983, hospitals have had greater concern with patient census. Many have created staff positions devoted specifically to recruitment and retention. Primary care specialists are a priority target.

"For the administrators, a key is the primary care physician who places patients in the hospital," says Alan Reiman, president of Private Practice Marketing, a healthcare firm in Skokie.

Restrictions on government spending and a severe squeeze on obstetrical services in rural Illinois have made acquiring the right medical talent a life and death affair for hospitals across the state.

"They're looking for physicians with admissions perhaps of 100 or more a year. The family practitioners, the obstetricians and gynecologists and internists are the ones who can bring revenue to the hospital."

The talent squeeze is most severe for family practitioners and above all obstetricians, exposed to huge malpractice insurance expenses.

"To get a family physician, a rural hospital would have to offer $60,000 to $120,000 guaranteed minimum income, after insurance premiums, overhead costs, and other expenses," said Adkisson. "And you can add free parking, no office rent for the first year, group purchasing discounts for medical supplies and help covering malpractice premiums."

According to Wellhausen, hospitals generally offer temporary start-up support. Typically, he said, a physician might have several years' use of an equipped office with a guaranteed salary before he'd be expected to begin reimbursing the hospital for them.

"The whole idea of bringing in a new physician is to increase inpatient billing at the local hospital," Wellhausen said. "That's how hospitals stay alive and healthy: the diagnostics, surgery and other care provided. But the hospital cannot pay a physician for patient referrals. That's illegal."

As the recruitment struggle sharpens, hospital administrators find themselves broaching ambiguous legal restrictions on gathering medical talent. The federal Office of the Inspector General has issued draft "safe harbor," regulations which will clarify many questions regarding practice arrangements that involve Medicare or Medicaid patients. Physicians considering a practice arrangement should ensure that their legal counsel has reviewed these regulations and ensured compliance with state and federal law.

Anti-inurement provisions of the Internal Revenue Code prevent tax-exempt organizations from lending their assets to private citizens if the facility fails to obtain an equivalent or greater return financially.

Hospitals extending cash grants outright to physicians may find themselves challenged by the IRS to prove that the grant was not unjustifiably high in relation to what the hospital got in return. Quantifying benefits like that, administrators have found, is very difficult.

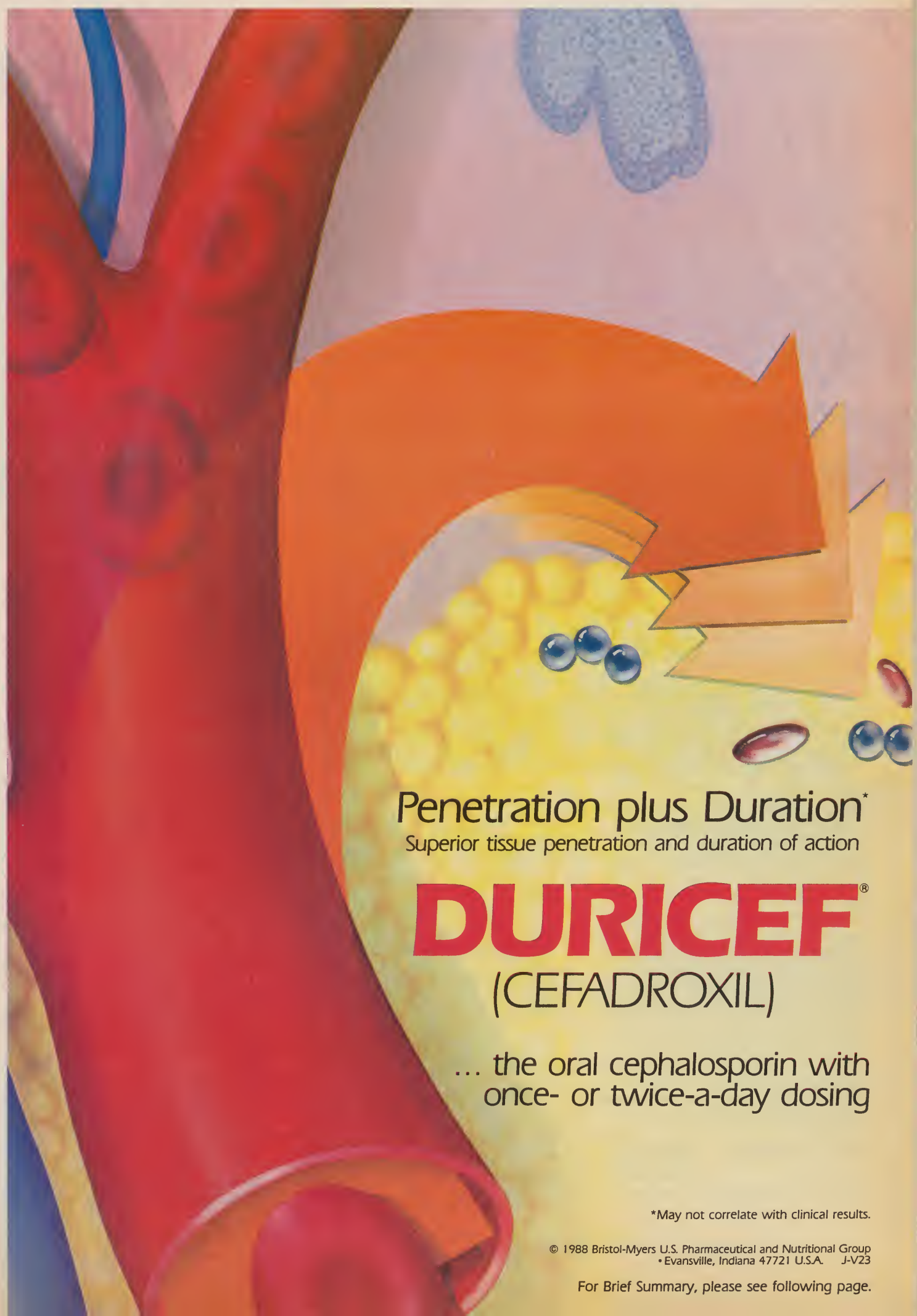
Isolated areas suffer most

Many hospitals outside the larger cities are unable to supply incentives, and their incapacity has deprived sections of Illinois of basic medical talent. The Illinois Department of Public Health surveyed the state last May and discovered that by federal and state criteria 32 of the state's 102 counties suffer from a shortfall of primary care physicians.

Illinois' definition of a shortage is less than one primary care physician per 3,000 persons, and the federal standard is one per 3,500. Two years ago the same survey put the number of deprived counties at 20, and researchers in Springfield say the figure is certain to climb even more.

One of the most deprived regions of the state is south of Interstate 64, where the obstetrical care shortage is most acute.

"We've seen babies born on buses, in parking lots and emergency rooms," says Barbara Dallas, an assistant director for the Illinois Hospital Association. *(continued on page 6)*



Physician Recruitment

(continued from page 5)

"You just can't get them to come to a rural area where the nearest airport is 100 to 150 miles away in St. Louis," Dallas says.

A Personal Choice

The indefinables—quality of life considerations, spouse preferences, affinity for high-tech equipment—are equally important, according to Wellhausen.

"Someone who volunteered to train in a small town would probably be happy in a rural environment because that's what they enjoy," he said. "He or she probably wouldn't be happy in an inner city practice." For others, he said, the urban practice is a great challenge, and the cultural advantages of the city are of overriding importance.

The biggest recruiting change over the last 15 years, according to Wellhausen, is the high-tech nature of medical education. "Physicians are now so highly trained in their residencies, that they've become accustomed to sophisticated equipment and back-up help," he said. "The doctor comes to depend upon his diagnostic tools and expertise for referral—without it, he or she feels that they aren't being conscientious."

These physicians are more often targeted by teaching hospitals, like Northwestern Memorial, which depend on prestige, university connections, and research activities to draw medical talent. "Our strategic plan calls for Northwestern to become a full-service, adult tertiary care hospital," says Cynthia Barnard, assistant to the president for medical staff affairs.

According to Barnard, department chairmen at the medical school select the physicians to recruit, and along with key administrators try to attract them by offering a faculty position (sometimes only part-time), laboratory and office space, a hospital salary for administrative duties (such as running a catheter lab) and minor perquisites like discounts on parking and office supply products. Northwestern also extends what it calls "orientation" to new physicians, which calls for meeting the president and senior management personnel.

Experts are also advising hospitals to acquire a "quality niche" to attract the attention of the public as well as quality practitioners. The strategy calls for identifying the hospital with narrow but high profile specialties, such as the University of Pittsburgh's Presbyterian University Medical Center.

"The University of Pittsburgh wanted to become the liver transplant center of the whole world," says James Neely, director of strategic marketing at Garofolo, Curtiss & Co., a healthcare recruiting firm in Ardmore, Pa. "Now its trainees are starting their programs elsewhere."

Cooperative Efforts May be Key

A number of observers point to successful Wisconsin programs, where the Monroe and Marshfield clinics were formed by physicians seeing the need for multispecialty health care in a rural area. Wellhausen believes

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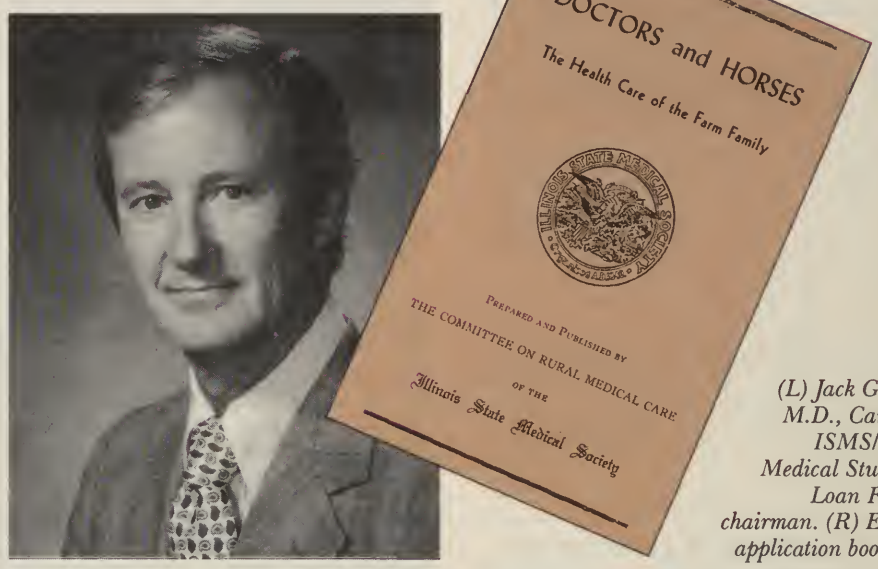
INDICATIONS: DURICEF (cefadroxil) is indicated for the treatment of the following infections when caused by susceptible strains of the designated microorganisms: Urinary tract infections caused by *E. coli, P. mirabilis,* and *Klebsiella* species. Skin and skin structure infections caused by staphylococci and/or streptococci. Pharyngitis and tonsillitis caused by Group A beta-hemolytic streptococci. (Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. DURICEF is generally effective in the eradication of streptococci from the nasopharynx; however, substantial data establishing the efficacy of DURICEF in the subsequent prevention of rheumatic fever are not available at present.)
Note—Culture and susceptibility tests should be initiated prior to and during therapy. Renal function studies should be performed when indicated.
CONTRAINDICATIONS: DURICEF is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.
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Any patient who has demonstrated a history of some form of allergy, particularly to drugs, should receive antibiotics cautiously and then only when absolutely necessary. No exception should be made with regard to DURICEF (cefadroxil). **Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use.** Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Moderate to severe cases should be managed with fluid, electrolyte and protein supplementation as indicated. When the colitis is not relieved by drug discontinuance or when it is severe, oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile.* Other causes of colitis should also be considered.
PRECAUTIONS: Patients should be followed carefully so that any side-effects or unusual manifestations of drug idiosyncrasy may be detected. If a hypersensitivity reaction occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).
DURICEF (cefadroxil) should be used with caution in the presence of markedly impaired renal function (creatinine clearance rate of less than 50 ml/min/1.73M²). (See Dosage and Administration section of Prescribing Information.) In patients with known or suspected renal impairment, careful clinical observation and appropriate laboratory studies should be made prior to and during therapy.
Prolonged use of DURICEF may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.
Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug. DURICEF should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
Usage in Pregnancy: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to 11 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cefadroxil. There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Caution should be exercised when cefadroxil is administered to a nursing mother.
ADVERSE REACTIONS: *Gastrointestinal*—Symptoms of pseudomembranous colitis can appear during antibiotic treatment. Nausea and vomiting have been reported rarely.
Hypersensitivity—Allergies (in the form of rash, urticaria, and angioedema) have been observed. These reactions usually subsided upon discontinuation of the drug.
Other reactions have included genital pruritus, genital moniliasis, vaginitis, and moderate transient neutropenia.
Before prescribing or administering, see package insert

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ISMS/IAA program logs 30 years in rural M.D. support

LONG BEFORE the physician shortage in rural Illinois was the subject of state agency and media scrutiny, the Illinois State Medical Society (ISMS) and the Illinois Agricultural Association (IAA) had joined forces to address the problem of supplying rural Illinois with physicians. The vehicle was the ISMS/IAA Medical Student Loan Fund, conceived in 1946 when Irving P. Coleman, M.D., Canton, was president of ISMS and Charles Shuman, Sullivan, was president of the IAA, the state subsidiary of the American Farm Bureau. These two organizations contributed initial funding to establish a trust fund and jointly approached the University of Illinois Medical School to gain support for the program. What resulted was an Illinois General Assembly Joint Resolution passed June 8, 1949, that allowed qualified applicants interested in rural practice to hurdle borderline academic barriers or find financial assistance for medical school enrollment in the University of Illinois. The first physician Board members were Doctors Coleman, Ed Hamilton of Kankakee and Harlan English of Danville.



(L) Jack Gibbs, M.D., Canton ISMS/IAA Medical Student Loan Fund chairman. (R) Early application booklet.

Jack Gibbs, M.D., Canton, was a medical student in 1949 and a program beneficiary. He has served as a member of the ISMS/IAA Medical Student Loan Fund Board since the mid-1950s, and as its chairman since the mid 1960s.

"Jack Gibbs has given much to ISMS in service and dedication," according to ISMS President-Elect, Eugene P. Johnson, M.D., Casey. And according to Randall Mullin, M.D., Geneseo, who serves on the ISMS/IAA Board with Gibbs, "Jack Gibbs is the backbone of the program and emblematic of everything it stands for."

"Illinois is unique in that various sectors—medical society, other associations and government—help medical students," according to Fred Z. White, M.D. of Chillicothe. "There is the ISMS medical student loan program, the ISMS/IAA medical student loan program and the Illinois Department of Public Health (IDPH) Family Practice Residency Program. I know of no other state with this many opportunities for assistance to medical students." The IDPH Family Practice Residency program requires primary care practice in an approved underserved Illinois area following completion of residency.

To be recommended by the ISMS/IAA Board for either University of Illinois medical school enrollment or funds loaned from the program's trust, a student must be an Illinois resident, achieve a minimum Medical College Admission Test (MCAT) score and document academic proficiency (3.5 on a 5.0 basis) in undergraduate school.

The student's character, geographic location of Illinois residence and—most important—promise to practice medicine in a primary specialty in rural Illinois for five years, are also weighed. "Our biggest problem in the last few years is medical students who take a walk," said Dr. Gibbs. "A significant number of medical students have not kept their word about their choice of primary care or practicing in a rural Illinois community."

According to Boyd E. McCracken, Sr., M.D., of Greenville, practicing medicine in an urban setting has no magic. "There are so many advantages in a small town," he said. "The satisfaction of taking care of several generations of the same family and knowing your people better is one. It depends on what makes a person tick and the basic philosophical bent of the physician and the spouse. Either they like [the small town] or they don't. It's important to be satisfied. I can't think of anything worse than being unhappy and wishing you were somewhere else."

In the early years of the program, the University agreed to accept three students. Over time that number has grown to around 20 students a year, with the University retaining the right of refusal based upon its academic standards. Between 25 and 35 recommendations are made to the University each year. A recommendation from the Board carries weight, but does not guarantee acceptance into medical school. "During the years when it was tough to get into medical school, our recommendations carried significant weight for admission," said Dr. Gibbs. "Our program participants have been good risks. Some have been class presidents and outstanding students." According to Mullin, "The University of Illinois Medical College Alumnae leadership has more than its share of program participants.

that a cooperative effort between rural communities and tertiary care centers seeking new markets will become a natural alliance in the next decade.

Carle Clinic and the Christie Clinic in Champaign County offer a hybrid approach.

"The solution for rural communities will often be satellite clinics," Wellhausen said. "A family practice or internal medicine physician would do primary care—the pediatric sutures, geriatric monitoring, a lot of diagnostics. He or she wouldn't do a great deal of surgery—they'd refer to the central clinic for obstetrics, plastics, and inpatient care."

Wellhausen explained that a central clinic might find a physician interested in rural practice and rent office space in a small town for one or two days per week to test the market. It's a way to draw business to the group and enables those who want a rural practice to establish one and survive economically.

"They're independent physicians working by themselves under contract with a large clinic group," he explained. "The group provides lower insurance rates, paid vacations, tax breaks, coverage and vacation time. He has the benefits of corporate backing in a rural community."

Professional Resource

Bruce Becker, M.D., is chair of the ISMS Subcommittee on Physician Placement, formed less than two years ago. "We've been studying the physician shortage situation in Illinois for some time now," Dr. Becker said, "and we've found a need for physicians in both the inner city and the rural areas. Our goal is to act as a clearinghouse, and assist both physicians seeking partners or group members and new graduates seeking positions.

"We're developing a list of agencies and individuals who can help new physicians, particularly contacts through the specialty groups. We're planning to provide a list of Illinois and national organizations representing all the medical specialties," he said. "The benefits, who can access them, costs, addresses, phone numbers. The resident will then know who to call for an initial step in seeking out practice opportunities."

Dr. Becker said that the many changes in medicine were forcing all of the players to take a fresh look. "Hospitals are looking for ways to maintain their census. One is more admissions, whether by their own physicians or new physicians," he said. "Another would be more ambulatory services, or a long-term care alternative, special pulmonary units or swing beds. The hospital's goal is to fill beds," he said. "The physician's goal is to provide appropriate care."

Dr. Becker characterized the satellite clinic alternative for rural care in much the same way. "I'm not sure whether it makes any difference whether you're put there by a clinic or on your own," he said. "What counts is your experience. If it meets your needs and your family's needs, you'll stay there and see your practice grow." ▲

Not only are these physicians out working in our communities, but they are serving the profession also. Most of them haven't just made a five year commitment; they have made a lifetime commitment."

Recommendations are made by the Board, which consists of three physicians, representing ISMS and three representatives from the IAA. Current physician Board members are all products of the program. The Board has agreed that the chairman will always be a physician. Board members representing ISMS and serving with Dr. Gibbs are Drs. Mullin and David Dunn, of Mahomet. "The program has brought more to rural Illinois than just the 250 or so physicians currently practicing in rural areas," said Dr. Gibbs. "Medical students in the program attract others to come into practice with them. They bring along a buddy, so the program has had a ripple effect. It has also allowed rural physicians to participate in the academic community and to add to the quality of professional life in small towns."

According to Dr. White, "In the late '60s and early '70s, medical education was concentrated in Chicago. The University of Illinois decentralized medical education with campuses in Peoria, Rockford and Urbana. The thinking was that medical schools downstate would help lure physicians to rural Illinois."

The Board's primary function is to interview prospective medical students in December and make recommendations to the University for their acceptance the following academic year. According to Dr. Gibbs, the Board looks for applicants who would be motivated and suited to small town practice. "There is a perception that life in a rural community is not desirable," said Dr. Gibbs. "If an applicant is not familiar with life in a small town, the perception may be one of isolation and backwardness. The perception may be that specialists may not be available, or equipment and backup, or that they [applicants] may not be able to practice medicine the way they've been trained. Nothing could be further from the truth, with today's means of travel."

In the summer, the Board meets with current program participants to allow the medical students to share experiences with the Board and other students. The Illinois Agricultural Association provides the staffing. That involves processing applications from candidates who meet the program's requirements. Students seeking financial aid are contacted after they have been accepted as University of Illinois Medical School students. Loans of $1,250 per semester are available during the four years of medical school and are granted at 4% interest. The interest must be paid annually, but repayment on the principal does not begin until three years after medical school graduation.

"With the most recent tuition increase at Illinois medical schools, this program should really be a help to Illinois medical students who qualify," commented George T. Wilkins, M.D., Granite City.

The program has an excellent loan repayment rate, with virtually no loan default. However, liquidated damages are assessed in the amount of $12,500 when a medical student does not locate in rural Illinois or does not choose a primary care (family pactice, pediatrics, general surgery, internal medicine and obstetrics-gynecology) specialty. "Sometimes the spouse doesn't want to live in a small town," said Dr. Gibbs. "I try to push postgraduate training in downstate Illinois. The biggest single factor in practice location choice is where you do your residency training."

The fund's total assets as of November 30, 1988, were 1.1 million dollars, with the ISMS and IAA equal partners. Over the years, ISMS has invested about $105,000, the most recent funds contributed from the Educational and Scientific Foundation. Each year at the ISMS Annual Meeting the ISMS/IAA Board makes an annual report to the ISMS House of Delegates on the status of the Fund. The program has assisted over 500 students with recommendations and/or loans. Nearly 250 physicians who are now practicing in rural Illinois are products of the program.

Dr. Gibbs said there is a dwindling pool of applicants nationally for medical school and the ISMS/IAA program is no exception. The number of applicants this year fell below 50 for the first time.



East Tower of the University of Illinois College of Medicine, Chicago

"I don't know if down the road this program will be as valuable as it has in the past," said Dr. Gibbs, referring to the decline in medical school enrollment. "I'm happy to have been a part of it. It's unlikely that those program participants practicing in rural Illinois would be where they are if it hadn't been for the program. It's been a lifelong concern of mine."

Students seeking a recommendation from the program must be in their fourth year of college and must have completed study for a bachelor's degree prior to matriculation to medical school. Applicants must be Illinois residents, and must have the signatures of their county medical society president or secretary and the county Farm Bureau president on their application form. The practice location is the applicant's choice, but subject to approval by the Board. According to James Schmidt, IAA staff person who manages the program, an informal network exists that makes it easy to match physicians to communities. "We don't have a formal placement service," said Schmidt, "but communities do contact us and let us know that they need a physician."

Interested applicants or communities can contact Schmidt at 1701 Towanda Avenue, P.O. Box 2901, Bloomington, Illinois 61701. ▲

For the Defense

A periodic column on matters of interest and relevance to the litigation process.

MD can be own best defense

Expert witness cross-examined

by Sean A. Kennan

JOSTLING THE CROWDS in O'Hare's wide corridors, he moves like a man in a hurry. He is. If things go right he'll dispose of two trials in one afternoon. If the expressways are clear, the cabs available, and the Loop's traffic not congested, he'll tell two different juries how they do it in Philadelphia; what the accepted standard of care is; and how he would have handled them if they had been his emergency room cases.

He's a doctor. For the last seven years he's made his living providing expert testimony in medical malpractice cases. A plaintiff's witness, he sells his services to a nationwide firm which specializes in evaluating the merits of, and supplying expert witnesses for, medical malpractice cases. In legal circles, he's sometimes regarded as a "hired gun".

Until recently, such questions as the amount of money he earns annually as an "expert," the number of times he's testified for plaintiffs versus defendants, and the percentage of his overall income derived from legal work were not allowed in Illinois medical malpractice trials. However, according to Saul Morse, J.D., ISMS general counsel, a decision handed down by the Illinois Supreme Court nearly a year ago, indicates that the courts have seen a dramatic shift in the role of the expert witness.

Morse is referring to the case of *Trower* vs *Jones,* in which the Illinois Supreme Court pointed out that expert witnesses can derive benefit beyond the simple compensation paid them by the prosecuting or defense attorney. "A favorable verdict may well help him establish a 'track record' which, to a professional witness, can be all-important in determining not only the frequency with which he is asked to testify but also the price which he can demand for such testimony," the court said.

Morse pointed out that an attorney might seek to demonstrate potential bias. "It is in the expert's economic interest to continue to say what the plaintiff's lawyer wants so he'll be used in more cases," he said. To the physician whose livelihood is derived from testifying in medical malpractice trials, the court's message is clear. Juries now have a right to include economic activity in their deliberations. The number of times a doctor has testified for plaintiffs, the percentage of annual income that generates, and the number of hours in any employment year which are devoted to preparing for and delivering



such testimony may all fall into a pattern and become a significant factor for consideration by a group of individuals who are asked to weigh the facts in a malpractice case.

Reinforcing that message is a new and more aggressive effort on the part of the Illinois State Medical Inter-Insurance Exchange to track the testimony of those experts whose view of a particular medical method or procedure changes from trial to trial. In these instances, the expert's own testimony will be used to impeach credibility. With an eye toward continuing to affect the tort climate in Illinois, the Exchange is examining cases more closely and cultivating a partnership between the insured physician, his or her defense attorney, and the Exchange's claims examiner. As a result of this partnership, the defense attorney now has someone available to collect information, catalog it, conduct research, and support the physician from the time a case is filed to its conclusion.

Robert C. Hamilton, M.D., Chicago, chairman of the Board of Directors for Illinois State Medical Insurance Services, Inc., attorney-in-fact for the Exchange, sees a direct relationship between the *Trower* v. *Jones* decision and the Exchange's

(continued on page 10)

THE LOWER RESPIRATORY TRACT—
More vulnerable to infection in smokers and older adults



Experience counts

Ceclor® Pulvules® 250 mg
cefaclor
think of it first

For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal (mostly diarrhea): 2.5%.
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.
Abnormalities in laboratory results of uncertain etiology
• Slight elevations in hepatic enzymes.
• Transient fluctuations in leukocyte count (especially in infants and children).
• Abnormal urinalysis; elevations in BUN or serum creatinine.
• Positive direct Coombs' test.
• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). 1061088LI

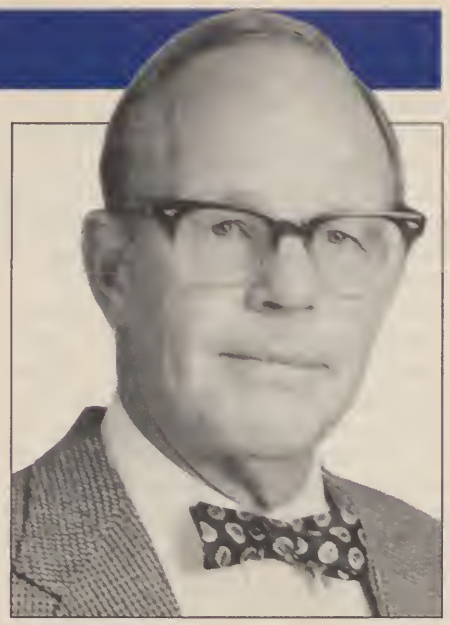
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Chairman's Letter

ISMIS focuses on claims management; greater physician role



Robert C. Hamilton, M.D.

PERHAPS ONE of the things that physicians dread most these days has just happened to you—you have just been notified that one of your patients is suing you for malpractice. What do you do? To whom do—or don't—you speak? What happens next?

If you are a member insured by the Illinois State Medical Inter-Insurance Exchange, your first call should be to the Exchange. Over the past year, there have been some important refinements in our claims management process; these refinements, we believe, will considerably strengthen the already excellent representation accorded Exchange policyholders. I would like to take a moment to apprise you of them.

If you live in the Chicago metropolitan area, one of the Exchange's experienced Professional Liability Analysts (PLA) will visit you to gather information about the case—your side of the story, if you will—and explain to you what will be happening at various stages of the process. This service, now mainly conducted by telephone, will soon be available to policyholders living outside of the Chicago area, with the opening of a Springfield claim office.

Usually, these meetings are conducted in your office. You are asked to have all your files and records on the case available. During the meeting, the PLA and you will discuss what happened in an effort to determine facts of the case. Diagnosis, treatment, procedures, personnel involved, and a narrative of what actually occurred during a given incident or incidents are all part of this meeting.

There are two very important things to remember about this initial phase. First, the more complete and accurate your records, the easier it will be to reconstruct exactly what happened. It is important that you provide a copy of the case records for the analyst, and be especially sensitive to how much any alteration of the records will adversely affect your case. Second, remember that the PLA is *not* there to question your expertise, impugn your integrity, or otherwise act "against" you. The purpose of the meeting is simply to understand what happened to cause the lawsuit so that a proper course of action can be determined and carried out.

Since, in most current malpractice cases, there are multiple defendants, the PLA will have similar meetings with each and every defendant. Following these meetings, the examiner may retain legal counsel to advise on the case. Qualified consultants who practice in your specialty are retained to review the case files and render an opinion regarding the appropriateness of care.

The Exchange's Physician Review Committee then studies the entire file to determine the appropriate course of action. In some cases the committee will recommend settlement; in others it will recommend aggressive defense. Others, with multiple defendants insured by the Exchange, will require multiple courses of action. In each case, the committee reviews the facts, identifies the strengths and weaknesses and makes a recommendation which it feels is in the best interest of the defendant individually, and all the members of the Exchange.

When the recommendation is to settle, the PLA seeks your approval to open negotiations with plaintiff's counsel. If the recommendation is to defend the suit, meetings are scheduled with an attorney; the strategy and conduct of the case are thoroughly discussed with you at every step of the process, including pretrial discovery, depositions, the pretrial conference, and finally, the trial itself.

One of the most important features of this process is that you are—and must be—totally involved. Because the court system is crowded with civil litigation of all kinds, a case may require months to years for final disposition. Through it all, the resources of ISMIS are at your disposal. Typically, one PLA is with you throughout, from that first fact-finding meeting in your office to the announcement of the settlement or verdict. Other resources include ISMS physician support groups; brochures and videotapes explain the process in more detail and offer advice on "how to cope."

One such videotape will be available in a few weeks. "Anatomy of a Claim" is a dramatization that was presented at the ISMS All Member Conference last November. It is the companion piece to the already-available videotape "Anatomy of a Malpractice Trial." Both of these tapes may be obtained on a loan basis through the ISMIE Network at 1-800-782-ISMS. Whether or not you are currently involved in a suit, we strongly urge you to view them and become better acquainted with how a malpractice claim is handled. In addition, our staff is available for any questions you may have. We urge you to contact them. ▲

Robert C. Hamilton, M.D.
Chairman
ISMIS Board of Directors

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled the case?

Presenting complaint—Skull fracture with right epidural hematoma.

Case outcome—Subsequent death

The case in brief—A 23-year-old male presented at an internist's office early in the evening complaining of head pain. The patient had no nausea and was not vomiting. The physician conducted a neurological examination. The patient did not have blurred vision, pupils were equal in reaction, and reflexes were normal. The physician prescribed medication for the patient's severe head pain. He later reported having unsuccessfully suggested hospitalization; the patient refused and left.

Within a few hours the Chicago Fire Department brought the man, who had begun experiencing seizures an hour earlier, to an area emergency room. Examination revealed that the right pupil was fixed and dilated, the left pupil was nonreactive and constricted, Doll's eyes

(continued on page 11)

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

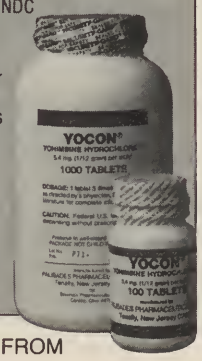
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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For the Defense

(continued from page 8)

new initiatives. "When cases do go to court, we can now attack the credibility of the professionally testifying expert witness—the person who may not even practice medicine," he said. "The Exchange's new program enables us to better serve the insured physician. *Trower* enables us to better protect him."

"When a physician is sued he or she enters a morass they will probably be in for years. We want that doctor to know that a representative of the Exchange will be there and will be responsive to his or her needs where the case is concerned."

"When the Exchange talks about a partnership between the defense attorney, a representative of the Exchange, and the physician, we do so because we believe these are the three key individuals involved in a malpractice case. The roles of the defense attorney and the Exchange representative may be self-explanatory; the part of the insured physician can't be emphasized enough. That person is the best resource available—much better than any expert brought into a case because they head a department in a leading medical school. Only the insured physician knows what was observed when the patient was examined; what questions were asked; what facilities for diagnosis were available at the time; what the patient said or didn't say; and why certain decisions were made."

Saul Morse agrees. "The defendant physician," he says, "is uniquely qualified to question an expert's testimony based on first-hand knowledge of the case. The insured doctor can say, for example, 'that's wrong because at the hospital where this procedure was performed they don't have support staff trained the way he (the expert) just said; they don't have diagnostic and other testing equipment the expert said he'd rely on; the response time to the hospital is "x" minutes and he's talking about a perfect world where the response time is less.' The doctor who was there knows these things better than anyone else and can be a most valuable asset in winning a case."

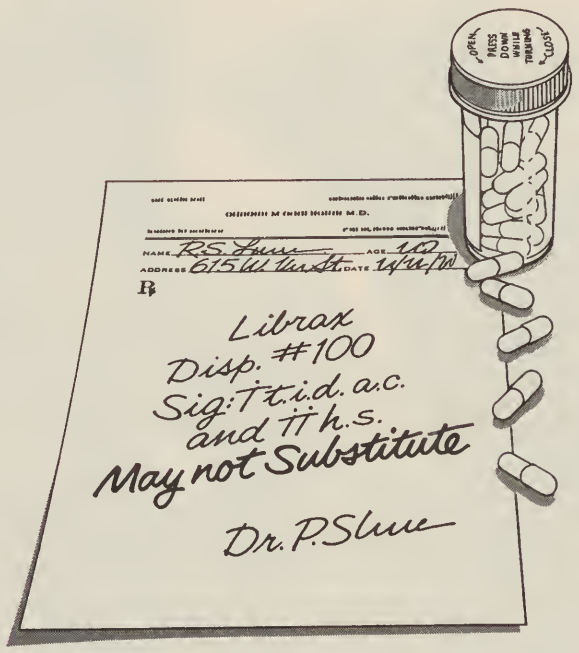
The physician defendant is uniquely qualified to question an expert's testimony based on first-hand knowledge of the case. . . . The doctor who was there knows these things better than anyone else and can be a most valuable asset in winning a case.

"That can't be done if the physicians don't actively and thoroughly participate in their own cases," Morse concluded. "They should be present for the deposition of the expert, to assist their lawyer and point out mistakes and identify important questions which should be delved into. They should be present for every hearing and present for every day of trial. Some of these trials may take up to a week or more and no one doubts the doctor has other very important things to do. However, the message that's sent to the jury if the doctor isn't there every day is, 'Well, he doesn't really care that much—let's find for the plaintiff.' That's a very important message."

Ed Butt, an attorney and partner in the law firm of Wildman, Harrold, Allen and Dixon, one of the malpractice defense firms retained by the Illinois State Medical Inter-Insurance Exchange, believes that a personal presence helps the jury to believe in and trust the defendant physician. "That person's active involvement and visible interest in his or her own case builds a certain level of credibility," he said. "Like twelve patients the jury will look to the defendant physician to explain the medicine, decision making process, and circumstances to them. The gains in tort reform made in 1985, particularly the case review requirement and the decision in *Trower* v. *Jones,* both constitute an advantage for defense attorneys in medical malpractice cases. Still, nothing speaks to a jury like the humanity of the person who was there at the time of the events in question providing care with the patient's best interests at heart." ▲

He's a doctor. For the last seven years he's made his living providing expert testimony in medical malpractice cases. A plaintiff's witness, he sells his services to a nationwide firm which specializes in evaluating the merits of, and supplying expert witnesses for, medical malpractice cases.

For the brain/bowel conflict of IBS*



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THE PEACEMAKER.

Antianxiety
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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Exchange Q & A

This column is intended to encourage communication between Illinois State Medical Inter-Insurance Exchange policyholders and their staff. Some of the most commonly-asked questions appear in today's column. Physicians are encouraged to submit queries to: Exchange Q&A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: What is a Certificate of Insurance and how can I request one?
A: A Certificate of Insurance certifies that the Exchange has issued a policy to the named insured. Hospitals and employers often request verification of insurance coverage, and the certificate fulfills that need. Requests for certificates should be submitted in writing to the Underwriting Department by the named insured (include policy numbers). They can be forwarded directly to the policyholder, or to a designated individual or organization. A new certificate is automatically issued at the time of annual policy renewal or when limits of liability are altered.

Q: How can I obtain approval for practice in a surgicenter?
A: A physician contemplating affiliation with a surgicenter should determine whether or not the center has been approved by the Exchange as a practice location. Surgicenters seeking approval should request and complete application forms from the Exchange to permit a prompt evaluation. Surgicenter personnel complete the forms and forward them directly to ISMIE. Once the Exchange has evaluated the surgicenter as a practice location, the physician is notified. ▲

Case in Point

(continued from page 9)

were present and plantar reflexes were unresponsive. There was a small abrasion upon the right temporal region. All findings were indicative of a head injury with intracranial bleeding. The ER physician telephoned the initial treating doctor and requested permission to hospitalize. This was given, and the patient was admitted under the service of a neurosurgeon.

A CT scan was immediately performed which showed increased attenuation at the right temporal area with pressure on the right lateral ventricle. The neurosurgeon operated that evening, based on scan findings consistent with epidural hematoma and edema. At surgery a skull fracture was noted overlying the parietal bone and upon lifting the skull flap a large epidural hematoma covering the right hemisphere from the temporal, parietal and occipital region was found. The dura was opened and the brain tissue appeared normal with no hematoma. Following surgery, the patient showed some physical improvement, but his neurologic status remained unchanged. Pneumonia developed and he was placed on antibiotics. He died in the hospital two months later.

The resulting claim—The patient's family filed suit against the physician who first saw the patient, alleging improper diagnosis and treatment, leading to his eventual death.

The outcome of the claim—The case was settled for $75,000.

Why problems arose with this case—The case could not be defended mainly because the records of the physician who first saw the patient were very poor. They did not adequately document his findings and the care provided, but merely referred to medications. After the suit was filed, the physician added notes to supplement the record, but the records provided no support for his statement that he had told the patient to go to the hospital if his head pain persisted. Nor did they support his assertion that there were no neurologic findings at the time of examination to suggest that immediate hospitalization was necessary. He also failed to follow-up aggressively and monitor the patient in the critical period following the initial office visit.

The point this case makes—Without complete, detailed records indicating dates upon which a patient was seen, the patient's reason for seeking care, his physical complaints, history, examination and test results, presumptive and discharge diagnosis, medications, types of treatment given, notations about any instructions given to the patient, and consent forms, a physician faced with a claim may face a brutal attack by opposing attorneys. "Jurors tend to put themselves in the patient's shoes. They feel that a physician should accurately record every fact concerning diagnosis and treatment," wrote Robert S. Pollock, MD, a San Francisco surgeon, in his book, "Clinical Aspects of Malpractice," published by The Medical Economics Company. "They will even relate missing or sloppy records to loss of life," he said, as happened in this particular case. ▲



An Important Message from APIC and its President:



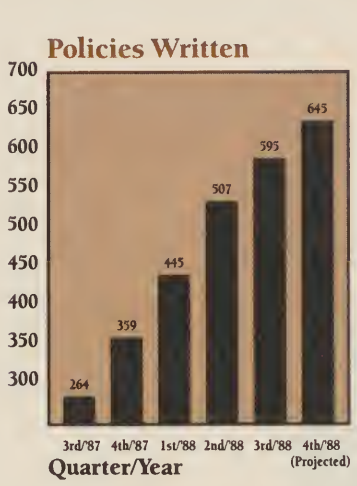
Henry Nussbaum
President
Associated Physicians Insurance Company

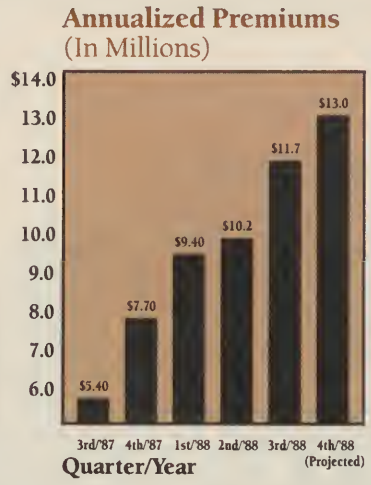
To Our Policyholders . . .

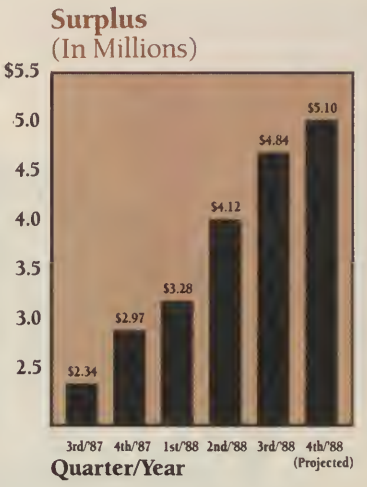
As we begin our third policy year of operation, I would like to say "thank you" to the policyholder/owners of Associated Physicians Insurance Company. Your intrepid support of APIC in its infancy is what made possible our emergence as the "other" physician-owned malpractice insurance company in Illinois.

The dedicated leadership of your physician colleagues on the Board of Directors has guided the remarkable growth of APIC through 1987 and 1988. With your input and support, APIC's board has crafted an operating philosophy that promises APIC will remain fiscally sound and competitively priced in 1989 and beyond.

As the accompanying charts clearly illustrate, APIC's growth in policyholders and in premiums written has been accompanied by similar growth in the company's surplus – the real measure of APIC's financial foundation. In addition, APIC's assets now exceed $12 million.







Today, we protect more than 600 physicians in every corner of Illinois and in virtually every clinical specialty. Each of you should be congratulated for believing in yourself and in your ability to create a viable professional liability insurance alternative. On a personal level, my involvement with APIC has provided the most satisfying experience of my 30+ years in the insurance business, and I thank you for the opportunity to be a part of APIC's success.

To Those Illinois Physicians Who Have Not Yet Joined Us . . .

We understand the caution that you have exercised by remaining with your current malpractice carrier. After all, your ability to practice medicine relies to some extent upon your insurance protection. That is exactly why the managers and directors of Associated Physicians have so diligently endeavored to deliver a professional liability alternative that addresses your most serious insurance questions.

We are proud of the fact that we are Illinois-licensed, and that we provide a unique blend of physician ownership, management by insurance professionals, and local service through independent agents located near you. We take pride in the reinsurance protection that insulates us from catastrophic losses. And we also are proud of the performance of our investment advisors, The Chicago Corporation, and of our auditors, Coopers & Lybrand.

Most of all, we are proud of our ability to provide you with premiums that are extremely competitive, while delivering important policy features such as "consent to settle" and free "tail coverage" for five-year policyholders who have attained age 55 and are retiring from practice. This exceptional combination of price and coverage creates an insurance value that is second to none.

We invite you to apply for coverage from Associated Physicians Insurance Company. For physicians with established practices, we offer "prior acts" coverage to protect you against unknown claims which may arise from past incidents – without paying the expensive "tail" premiums charged by your current carrier. For physicians in their first three years of practice, we offer our "new in practice discount" that can save you up to 60 percent on our already competitive premiums.

Most importantly, we treat all of our policyholders as if they own the place . . . because they do!

Henry Nussbaum

Henry Nussbaum
President
Associated Physicians Insurance Company

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ASSOCIATED PHYSICIANS INSURANCE COMPANY

Rockford wrestles with new trauma network

by Janice Rosenberg

THE NEW STATE Emergency Medical Services Act of 1986 was fully implemented as of October 1 of last year, when the Illinois Department of Public Health completed the required level one and level two trauma center designations. As expected, the designations raised few eyebrows in some parts of the state, but created significant concern in others. In at least one instance, leadership from business and medicine have launched an effort to address what they believe to be a negative impact in their community. With the new system, Rockford Memorial Hospital and St. Anthony Medical Center became state-designated level one trauma centers. A third local hospital, SwedishAmerican, was designated as a level two center.

"The idea by the state to set up a trauma network was a good one," says Raymond E. Hoffmann, M.D., a general surgeon at St. Anthony. "But in Rockford this has led to hospitals having to spend money to keep things as they were prior to designation."

Designation as a level one center requires that a hospital have a full trauma team of physicians, nurses, and other personnel on call twenty-four hours a day. They cannot be treating nontrauma patients or doing other work while they are on call.

Rockford is a small city in which travel times are short. According to Dr. Hoffmann, a surgeon can reach any of the hospitals from home within six to seven minutes after the patient's arrival at the hospital. "We were giving good care before," he says, "With good accessibility. Why spend dollars to fix something that wasn't broken?"

With this in mind, the Rockford Council for Affordable Health Care recommended that the state law defining trauma designation be changed. The council, a coalition of area employers, insurers, hospitals, and physicians whose purpose is to contain increases in health care costs while enhancing quality, held a board of director's meeting on December 19, 1988. U.S. Senator Paul Simon, State Senator Joyce Holmberg, and State Representatives Edolo "Zeke" Giorgi and John Hallock were in attendance.

While questioning the need for multiple level one trauma centers in Rockford, the Board cited the cost factor and suggested alternatives including redefining the current definition of level one trauma centers to take into account communities like Rockford with three hospitals within close proximity. The Board also reported that a council staff study had failed to establish the need for even one level one center.

Level two designation costs hospitals less money, as the twenty-four hour on-call rule does not apply to them. In theory, all three Rockford hospitals could apply for level two status, but in that case they would be forced to serve under the auspices of a level one hospital in another state region. "The level one hospital would be far away," says Dr. Hoffmann, "Loyola in Chicago, for instance. We don't want to relinquish control of our patient population. We want to keep a level one in the region without spending so much."

A further complication may occur depending on the outcome of an effort at merger now underway between Rockford Memorial and SwedishAmerican. The two hospitals have completed all work for the merger, but the Federal Trade Commission has brought a suit against it. In the near future, the courts will decide whether to allow the merger. If the merger does *not* go through, according to Johanna Lund, the Rockford Council's Executive Director, SwedishAmerican, too, will likely seek level one designation in order to be competitive. Whether the law will be changed remains to be seen. ▲

ISMS Annual Meeting to be held April 7, 1989; Resolutions deadline March 8

THE ISMS HOUSE of Delegates' annual meeting will convene Friday through Sunday, April 7-9, at the Westin O'Hare Hotel. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 8, 1989. Those received after that date will be considered late resolutions and require special action for possible consideration.

In accord with House policy, resolutions published in *Illinois Medicine* identify author and subject only. Resolutions received in the ISMS offices by an earlier deadline, February 6, 1989, will be so identified in the March 3 issue. ▲

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Concluding a two-part series

HMOs see steady growth

by Karen Sandrick

The January 6 issue covered an assessment of Illinois' HMO industry. This conclusion looks ahead to further short term turbulence—and likely long-term stability.



ALTHOUGH MOST health maintenance organizations (HMOs) in Illinois posted deficits in 1987, a few made money because they knew their markets, because they developed solid market niches, and because they defined strategies for dealing with declining margins.

Still, even the profitable Illinois HMOs can look forward to turbulent times as membership growth stalls. James H. Austin, Jr., MPP, MURP, Chicago, reported at the Group Health Institute (Chicago, June 27, 1988) that HMO enrollment in Chicago and its six-county contiguous area will steadily slip. In Chicago and its surrounding counties, nearly 15% of the total population and between 25% and 30% of all eligible employees are currently enrolled in HMOs. "So HMO penetration already is fairly high," he said.

And even though HMO penetration downstate is low to moderate, there are no huge blocks of employees or populations that are ripe for HMO enrollment.

Because of stabilization of the HMO market and continued competition, the total number of HMOs in the state of Illinois will drop in the next few years. "There is definitely going to be some consolidation of HMOs," said Barry Averill, president of the Illinois Association of HMOs. "There are some national insurance companies that are deciding whether to stay in or get out of the health insurance business, [and one or more of these] may fold their organizations here or sell [their HMOs] to other companies."

In addition, "Some of the smaller hospital-based HMOs probably are going to become part of larger organizations," Averill predicted.

Belt-tightening likely

Meanwhile, because of recent heavy financial losses, individual HMOs will be improving internal operations. According to Frank E. Nicholson, vice-president of HMO Illinois, "Any time you go through the kind of year that the industry had in 1987, you have to look at every part of your organization to determine how you can be more effective and efficient. If you have any inherent weaknesses or inefficiencies in the way you operate or in the structure of your product, you have to take a hard look at operations and in some instances change management or tighten controls."

In order to survive and thrive in Illinois' mature, competitive HMO market, "You have to be better than someone else," Nicholson acknowledged. "You have to have a combination of a very competitive price and a reputation for a quality product."

Consequently, HMOs will be raising premiums, placing more emphasis on quality, and, Nicholson believes, instituting some cost sharing on the part of HMO members for discretionary services.

Premium increases predicted

A recent survey of 47 health maintenance organizations across the country by Group Health Association of America, Washington, DC, found that HMOs would be raising their premiums in 1989 an average of 16.9 percent. Most of the plans (25) said they would raise premiums 10 to 20 percent; nine said their rates would increase 20 to 30 percent; and three reported increases of more than 30 percent.

Rates were rising, the HMOs indicated, because of inflation, increased costs of hospital and physician care and pharmaceuticals, and because of plans' efforts to bring premiums better in line with expenses.

Illinois HMO rate increases for 1989 appear to be consistent with these national figures. According to Bob Petrusiak, president of Dyer HMO, Aurora, and chairman of the Illinois Association of HMOs' committee on public relations, statewide estimates of HMO premium increases range from 15 to 30 percent,

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and the increases are being planned to make sure rates are consonant with expenses.

"For a long time, competition has resulted in reduced rates; plans were going in and trying to buy the market, and one way to do that is by decreasing your rates. But now, many plans are realizing that is a sure way to commit suicide," Petrusiak says.

Clearly, in the upcoming three to four years, the Illinois HMO industry will be undergoing many changes. Nonetheless, health care authorities are convinced that once HMOs navigate through the stormy immediate future, they will have smooth sailing.

After all, nationally "we're seeing an increasing trend toward managed care," observed Joel Shalowitz, MD, MM, director of hospital and health services management, Northwestern University, Evanston.

HMOs nationwide have grown at an average annual rate of 20% over the last three years. According to Kenneth S. Abramowitz, health care analyst with the New York investment firm Sanford C. Bernstein and Co., HMOs and preferred provider organizations (PPOs) will control 80% of the U.S. health care market by 1997 and managed fee-for-service will control an additional 10%.

HMOs' future expansion will be spurred by employers who will become unwilling to continue paying for escalating health care costs once they see these costs start to erode their profits, Abramowitz said in his keynote address at the Group Health Institute.

HMOs are not now the first choice for many employers. However, "because of their inherent structure, HMOs make it easier [for employers] to manage and predict costs over the long term," said Nicholson. Unlike the traditional indemnity program, which is very open-ended, HMOs have cost and utilization controls built in their reimbursement packages or in their use of primary care physicians as gatekeepers, Nicholson noted.

In Chicago and its surrounding counties, nearly 15% of the total population and between 25% and 30% of all eligible employees are currently enrolled in HMOs.

At the present time, HMOs in Illinois have some little room to grow. "There are some markets on the West Coast and in Minnesota that are up to 40-45% HMO penetration. In Chicago, we're only at about 20%, so we have a way to go," said Averill.

Although Illinois HMOs are still growing, "the percentage of growth is going down, and eventually the market will be saturated," Averill continued. "Then as we mature we'll have to start reaching different markets."

HMOs should be able to move into new markets, Averill said, because "the cost of medical care is going up at twice the rate of inflation; so people will continue to look for ways in which they can get health coverage in a less expensive way."

"What the marketplace is buying," Nicholson concluded, "is value, and by providing a combination of price and quality, HMOs are a value." ▲

Obituaries

****D'Elia**
Dr. Rudolph D'Elia, of Hammond, Indiana, died November 12, 1988, at the age of 82. Dr. D'Elia was a 1936 graduate of the University of Health Sciences/Chicago Medical School, Chicago.

Fillman
Dr. Eldon M. Fillman, of Topeka, Kansas (formerly of Gardner), died October 11, 1988, at the age of 67. Dr. Fillman was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

****Hasbrouck**
Dr. Ellsworth E. Hasbrouck, of Chicago, died November 15, 1988, at the age of 75. Dr. Hasbrouck was a 1937 graduate of the University of Alabama School of Medicine, Birmingham.

***Kast**
Dr. Eric C. Kast, of Chicago, died November 28, 1988, at the age of 72. Dr. Kast was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

Kraynak
Dr. Mitchell A. Kraynak, of Effingham, died November 7, 1988, at the age of 35. Dr. Kraynak was a 1978 graduate of Loyola University Stritch School of Medicine, Maywood.

***Malsbury**
Dr. Charles W. Malsbury, of Chicago, died August 25, 1988, at the age of 73. Dr. Malsbury was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

Mercey
Dr. Raymond J. Mercey Peoria, died October 29, 1988, at the age of 95. Dr. Mercey was a 1918 graduate of the University of Illinois College of Medicine, Chicago.

****Piszkiewicz**
Dr. Frank J. Piszkiewicz, of Chicago, died August 18, 1988, at the age of 83. Dr. Piszkiewicz was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Schmidt**
Dr. Frederick R. Schmidt, of Chicago, died November 16, 1988, at the age of 90. Dr. Schmidt was a 1921 graduate of Rush Medical College, Chicago.

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News Capsules

MEDICARE ADMINISTRATIVE EXPENSES REPORTED

The ISMS House of Delegates adopted Substitute Resolution 34 (A-88) which directs the ISMS to publish, on a continuing basis, specific financial information on the portion of dollars allocated for the health care of the elderly but spent on administrative expenses. The following represents the second publication of this information.

For the first six months of 1988, Medicare Hospital Insurance Trust Fund (Part A) expenditures totalled $26.7 billion. Of this, $0.41 billion, or 1.5%, was spent on administrative expenses. This compares to a 1.6% rate for all of 1987. The Medicare Supplementary Medical Insurance Trust Fund (Part B) expenditures totalled $16.6 billion. Of this, $0.63 billion, or 3.8%, was spent on administrative expenses. This compares to a 3.0% rate for all of 1987. Overall Medicare administrative expenses for the first six months of 1988 were $1.04 billion, or 2.4% of Medicare health care expenses.

MEMBERS IN THE NEWS

Marshall A. Falk, M.D., Northbrook, vice president and dean of the University of Health Sciences/The Chicago Medical School, has been reappointed to a two-year term as a member of the Illinois Hospital Licensing Board. . . . The American College of Emergency Physicians recently announced the election of **Jacek (Jack) B. Franaszek, M.D.,** Naperville, to the position of president of its board of directors. Dr. Franaszek is an emergency physician affiliated with Hinsdale Hospital and Bolingbrook Medical Center. . . . **Michael S. Huckman, M.D.,** Evanston, was elected an honorary member of *Sociedad de Radiologia de Brasilia.* Dr. Huckman is a diagnostic radiologist and nuclear medicine specialist at Rush-Presbyterian-St. Luke's Medical Center, Chicago. . . . **Virgilio Jonson, M.D.,** Oak Lawn, has recently assumed the presidency of the Phillippine Medical Association in Chicago. The PMAC has also announced that **Pedro Lucina, M.D.,** Chicago, is recipient of its 1988 Distinguished Physician Award for his leadership, dedication and contribution to his community. Dr. Lucina is a surgeon affiliated with Roseland Community Hospital in Chicago.

The Chicago Geriatrics Society has named **Bertram B. Moss, M.D.,** as honorary and permanent director. Dr. Moss, the first to receive this honor, has served in numerous positions related to geriatric medicine throughout Illinois. . . . **George F. Ofori-Atta, M.D.,** South Holland, was appointed chief of staff of Saint Bernard Hospital, Chicago, at the annual meeting of the board of directors on September 15, 1988. Dr. Ofori-Atta is chairman of the department of surgery at Saint Bernard.

Henri S. Havdala, M.D., chairman of the department of anesthesiology and medical director of respiratory care at Mount Sinai Hospital Medical Center, Chicago, has been named professor and chairman of the department of anesthesiology, Chicago Medical School. Dr. Havdala is a member of the Illinois State Medical Inter-Insurance Exchange Board of Governors' Risk Management Committee.

Fred Z. White, M.D., Chillicothe, has been named director of the family practice residency program at Methodist Medical Center, which is affiliated with the UI College of Medicine at Peoria. Dr. White, who has a private practice in Chillicothe, is also chairman of the Board of Governors for the Illinois State Medical Inter-Insurance Exchange. He is a past president of ISMS, current medical director of Health Plan of Central Illinois and president of the Central Illinois IPA.

Leroy Sprang, M.D., senior attending physician in obstetrics and gynecology at Evanston Hospital, has been named secretary of the professional staff for the Evanston Hospital Corp., which operates Evanston and Glenbrook Hospitals. Dr. Sprang is a member of the ISMS Delegation to the American Medical Association. . . . The Lake County Medical Society recently presented their distinguished service award to **John J. Ring, M.D.,** Mundelein, chairman of the AMA Board of Trustees. . . . **James W. Girardy, M.D.,** Rockford, has been appointed to the Illinois State Emergency Services Council. . . . St. Mary's Hospital of East St. Louis recently presented their Wilson H. West award to **Charles Frazer, Jr., M.D.,** in recognition of dedicated service to the St. Clair County Medical Society and ISMS.

The Chicago chapter of Physicians for Social Responsibility recently hosted a visit by two Soviet physicians and a medical student, according to PSR member David Rothstein, M.D. The guests shared a dinner with local physicians, visited a Chicago Public School, and spoke before groups at the University of Chicago Medical School and Rush Presbyterian-St. Luke's Medical Center. ▲

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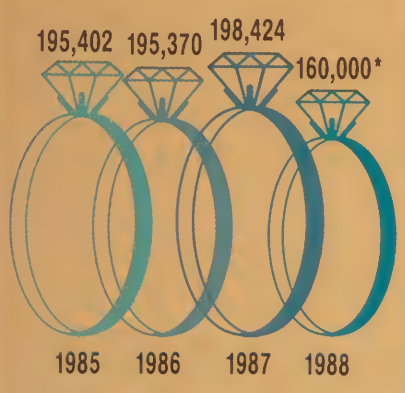
Medical licensing rules in effect . . .

Illinois Medicine

February 3, 1989

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Premarital AIDS test costly to couples, ineffective as screen; IDPH to seek repeal

YEAR-END PROJECTIONS from the Illinois Department of Public Health (IDPH) show that while the efficacy of Illinois' premarital AIDS testing law has not been proven, its costliness is beyond a reasonable doubt.

Required HIV screening tests for the 160,000 persons issued Illinois marriage licenses last year yielded 23 cases of AIDS antibody sensitivity. Using a conservative $35 cost-per-test, IDPH spokesmen project that Illinois' newlyweds spent $5.6 million on required AIDS screening tests last year. Simple division yields a $243,500 cost-per-case identified through the premarital screening law.

According to Illinois Department of Public Health spokesman Tom

(continued on page 7)

Illinois' medical indigency problem: no ready answers

by Tina Panoplos

THEIR LOW INCOMES make a routine visit to a doctor's office a trip they can't afford to make. And when low-cost clinics or other services make medical care financially accessible, they often face other barriers—geographic, educational or even psychological—that keep them from seeking care.

These are the medically indigent, the estimated 1.5 million people in Illinois who fall in the gap between those who can afford health insurance and those who qualify for public aid. And in Illinois, as throughout the nation, that gap is widening.

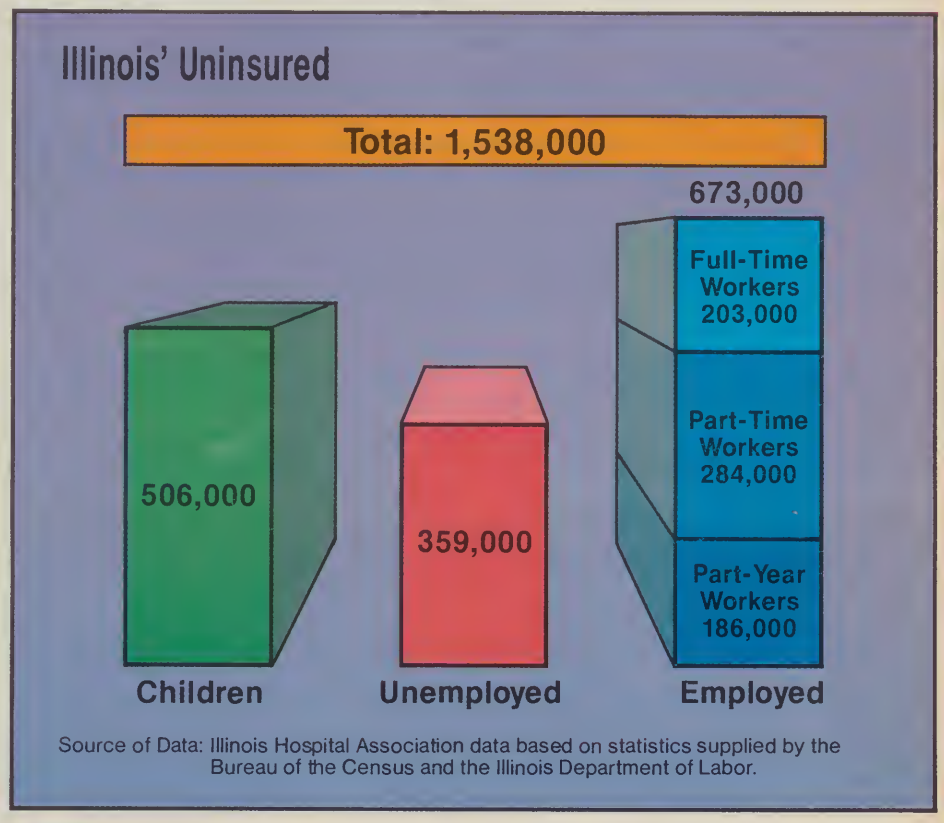
The medically indigent population grew nationally by 25 percent from 1980 to 1987.

"It's becoming a major health policy problem for every state," said Laura Landrum, chief of the division of health policy and finance for the Illinois Department of Public Health.

Landrum said that medical indigence is primarily a problem of the working poor, people who work full- or part-time for employers who either don't offer health insurance or who offer insurance with prohibitively high employee premiums, copayments, or deductibles. Also affected are family members of employees who either don't have insurance or carry insurance for themselves alone. In these cases, either spouse and dependent coverage is unavailable, or their portion of the coverage cost is prohibitive.

Who are they?

According to the Illinois Hospital Association, almost half of Illinois' medically indigent work at least part-time; about 70 percent have annual incomes of less than $10,000. More than half are younger than 25 and one-third younger than 18.





Edward Novak, chief executive officer, Sacred Heart Hospital, Chicago: patients face many barriers to care.

While about 50 to 60 percent of the medically indigent live in Cook County, Landrum said that proportionately the population is widely distributed throughout the state.

Physicians on staff at Sacred Heart Hospital on Chicago's west side often find themselves treating patients who are unable to pay for their services. "I know that happens on a daily basis," said Edward Novak, the hospital's chief executive officer.

Uninsured hospital patients represent only a fraction of the local medically indigent population. Novak noted other barriers that some of the medically indigent face—the mother who must travel with young children in tow, taking more than one bus to reach a health care provider who offers free or low-cost care, or the elderly person whose physical condition makes it difficult to travel or who lives in a neighborhood where he is simply afraid to leave home. Downstate, when safety is not at issue, distance sometimes is: residents

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Legislators vote start-up CHIP funding

ON JANUARY 10, the Illinois General Assembly approved $5.8 million in long-delayed start-up funding for Illinois' Comprehensive Health Insurance Plan (CHIP).

Enabling legislation to establish CHIP, a state-backed health insurance plan to provide affordable coverage for medically high-risk persons, had carried a January 1, 1988 effective date, but the program had not been funded.

"CHIP is a program for people who can afford insurance but cannot obtain it," said Illinois Department of Insurance Assistant Director Richard Carlson. Policies, he said, will be available to Illinois residents who are ineligible for Medicaid and have proof that insurance companies have rejected coverage due to a pre-existing condition. Those who have been offered substantially similar coverage at a rate exceeding that of CHIP because of a pre-existing medical condition will also be eligible. Finally, he said, the Board has identified 32 "presumptive conditions" for which eligibility is granted without an insurance company letter because coverage is not generally available.

Carlson said that the CHIP Board has hired an outside actuary to assist them in revising rates established last spring. "The actuary identified the five largest individual carriers in the state for health insurance coverage and averaged the individual rates," he said. "The Board used 135% of that as the CHIP base rate." Final rates will fluctuate by age, sex and geographic location of the applicant.

The size of the CHIP is effectively determined by annual state subsidy appropriated by the Illinois legislature. Lower appropriations mean higher premiums and, ultimately, fewer persons able to afford coverage. The current appropriation is a supplement to the fiscal year 1989 budget; Illinois legislators must next appropriate funding for the July 1989-June 30, 1990 fiscal year.

Carlson said that both the Department and the Attorney General's office have been accumulating names of persons who have called with interest in CHIP participation. When applications are available, they will be sent in a single simultaneous mailing to all persons who have requested them. The mailing will be coordinated by the plan administrator, Mutual of Omaha.

The list of pending applicants, Carlson said, will be made up of those who have returned completed applications and checks. There will be no list of pending applicants until actual applications are received. And persons who currently have insurance should not permit it to lapse in anticipation of a CHIP policy. "Applicants must still apply and then await word that they have been accepted by the CHIP," Carlson said.

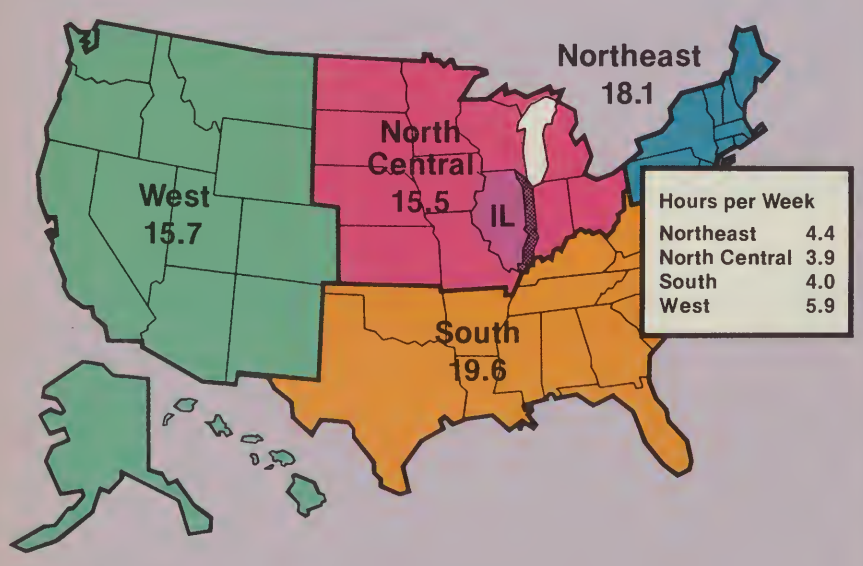
The state appropriation places a ceiling on the total number of people who can participate in the CHIP. "While there hasn't been a final decision as yet, we expect that the Board will allocate policies on a first-come first-served basis," Carlson said. "Approved applications beyond the initial accepted number will go on a waiting list."

A general description of the program will be available within a few weeks. Details on premiums and coverage will accompany the actual applications mailed in late March, and the first policies should be written effective April 15. ▲

Physician Facts

Percent of Physicians Providing Uncompensated Care

(To Patients Outside the Physician's Practice)
By Region, 1987*



***Region Divisions**

Northeast:	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
North Central:	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South:	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West:	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Source of Data: American Medical Association: *Socioeconomic Characteristics of Medical Practice, 1987.*

UI/Michael Reese pact nears; spinoffs multiply

by Kevin O'Brien

THE UNIVERSITY of Illinois Board of Trustees voted 8-1 on January 12 to approve "in principle" an affiliation agreement between the University of Illinois Hospital and Michael Reese Hospital and Medical Center.

Under the proposed agreement, Michael Reese would become the primary teaching facility for students attending the health professional colleges of the University of Illinois at Chicago. In addition, the agreement also provides for negotiations to lease the 500-bed university hospital to the Cook County Board of Commissioners.

The agreement, which brings Michael Reese into the University of Illinois system, marks the end of its long-time affiliation with the University of Chicago Hospitals.

University of Illinois Hospital spokesman Michael Maggio said the proposed agreement represents a "policy framework" under which further negotiations can take place.

John Skosey, M.D., president of the University of Illinois Hospital medical staff, said he was pleased that the Board withheld final approval. He said that 550 faculty members of the University of Illinois College of Medicine had submitted a petition asking that the Board delay the final approval until faculty concerns could be addressed.

The petition recognized the "potential benefits" of the affiliation with Michael Reese, but said that the agreement "grants to an outside institution inappropriate and unacceptable control over the academic directions and governance of the University of Illinois."

The petition cited faculty concerns that include the loss of university prerogatives in the appointment of its department heads, loss of freedom to establish and maintain affiliations with other hospitals as well as other professional colleges of the university, loss of the presence of the clinical department heads from the academic community of the university, and an overall concern for the care of the medically indigent.

Negotiations are also ongoing to achieve an affiliation agreement between the University of Illinois Hospital and Cook County Hospital, as well as a plan for the county to lease the university's 500-bed hospital.

Many observers applaud the lease idea because it could help solve the current county hospital dilemma. The county needs to replace its current aging and overcrowded facility, and wants to acquire Provident Hospital, which has been closed since September 1987. Combining the Provident acquisition with the university hospital lease would ease the pressure to build a new county hospital. Critics of the plan, however, say that it further widens the gap between rich and poor because privately insured patients would go to Michael Reese, while public aid and medically indigent patients would end up at County.

Michael Reese president Henry Nadler, M.D. candidly acknowledges that Michael Reese cannot afford to absorb many public aid patients from the University of Illinois. "It would be our plan, unless something dramatic happens, . . . to go in and try to contract for the same number of [IDPA] days we now have," he said.

Michael Reese spokeswoman Andree Dolan said that the hospital had $93 million in uncompensated care during 1987, which was 30 percent of its total revenues. However, Nadler said that he expects that some University of Illinois public aid patients would transfer to Michael Reese, providing that reimbursement would be within the contractual number of Medicaid days.

Cook County Hospital director Terrence Hansen concurs, saying that he expects to be able to contract for additional Medicaid days once negotiations with the University of Illinois are completed. Hansen also has proposed using the university hospital as an obstetrical and pediatric center which would consolidate operations in one location and make effective use of current staff.

Meanwhile, Hansen also hopes the county's effort to acquire Provident on Chicago's south side will succeed. Complicating those efforts is the New Provident Community Hospital Association, a local group of churches, labor unions, community organizations, and individuals who offered $7.5 million to buy the hospital's $14.6 million mortgage held by the U.S. Department of Housing and Urban Development.

However, the U.S. Attorney's office in Chicago said it would seek foreclosure on the hospital, effectively putting the facility up for auction, and possibly pitting the county board against the community organization.

Hansen would not confirm whether the county actually intended to bid, saying only, "We're waiting for it to come on the auction block."

The ISMS Resident Physician Section (RPS) Chairman Bruce Doblin, M.D., reporting on resident concerns at the January 21 ISMS Board of Trustees meeting, said that the three combined training programs incorporate nearly 25 percent of Illinois residency positions and that residency issues should be addressed in negotiations. "We will be continuing to monitor all aspects of the proposed affiliation," he said. ▲

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State issues medical licensing rules

Regulations implementing fundamental changes in medical licensing provisions of Illinois' Medical Practice Act were published as emergency rules in the January 13 Illinois Register. *The rules implement medical licensing provisions of the 1987 Act as well as 1988 amendments concerning pre-1985 graduates. They include changes of particular import to new medical residents, residency program directors, others seeking permanent, temporary or limited temporary licensure and pre-1985 graduates.*

Illinois Medicine *interviewed officials with the Department of Professional Regulation (DPR) to secure a straightforward assessment of the rules' impact. Michael Accettura, DPR general counsel, Pat Eubanks, assistant manager, Health Services Section, and Maureen Mullhall, administrator, Medical Practice Act, spoke for the Department.*

IM: In brief, what key changes in medical licensure are reflected in the new rules?

DPR: All applicants for permanent licensure are now required to complete two years of postgraduate clinical training, instead of only one year as formerly required. There is no distinction between graduates of medical schools approved by the Liaison Committee on Medical Education (LCME) and schools not approved by the LCME, or between graduates of United States and foreign medical schools.

Also, the state no longer approves medical programs. All applicants are judged on the same educational criteria. Each must complete minimally a six-year post-secondary course of study, of which at least two years must be in the basic sciences. An additional two years must be in the traditional core clinical rotations of surgery, obstetrics/gynecology, pediatrics, psychiatry and internal medicine. The core rotation must be completed in a facility that is owned, operated or affiliated with the applicants' medical school. And that affiliation must be documented with a signed copy of a formal affiliation agreement.

IM: What are the rules regarding the affiliation agreements?

DPR: All applicants for permanent, temporary or limited temporary licenses must submit affiliation agreements for *each* teaching facility in which they completed a core clerkship rotation prior to applying for a license. The affiliation agreements must be executed by both the administrator of the clinical teaching facility and the medical college dean, and must clearly define the role and authority of the governing body of each institution. In addition, evaluation forms signed by the supervising physician for each rotation completed must accompany the affiliation agreement.

IM: What are the changes regarding pre-1985 medical graduates?

DPR: Applicants for *permanent* licensure who graduated from a medical school that is not approved by LCME on or before December 31, 1987 must either hold a valid Illinois temporary license, or be licensed in another jurisdiction. If they hold a valid license from outside of Illinois, they must either have graduated from a medical school program approved by the Department of Professional Regulation prior to January 1, 1988, or meet the six-year post-secondary requirement.

Applicants for *temporary* licensure who graduated from a medical school not approved by the LCME are similarly subject to the six-year post-secondary requirement. However, if the applicants are applying after January 1, 1989, their applications will be subject to review by the Department's Medical Licensing Board (MLB) if the applicants graduated before January 1, 1985.

IM: How long should it take to get a temporary license?

DPR: Assuming all necessary application materials have been received by the Department of Professional Regulation, and further assuming the application falls within normal criteria and does not require MLB review, the hospital residency program should receive an applicant's temporary license within one month of receipt of a completed application.

IM: When are applications due?

DPR: State regulations provide that applications must be received at least 60 days prior to the start of the applicant's residency program. Applications are due on May 1 for programs beginning on July 1. Applications received after May 1 are still processed, but the Department cannot guarantee that a license will be granted by July 1.

(continued on page 12)

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REPORT FOR *Illinois Physicians*

BCBSI INSURANCE CARD GUIDE
MEDICAL SERVICES ADVISORY PROGRAM

The Medical Services Advisory (MSA) Program is a health benefits management program designed to assist Blue Cross and Blue Shield of Illinois (BCBSI) subscribers in interpreting and understanding their benefits. The Medical Services Advisor will work with the hospital, physician, and subscriber to determine the course of treatment which will maximize the benefits provided under the subscriber's Blue Cross and Blue Shield of Illinois coverage.

The basic components of this program are:

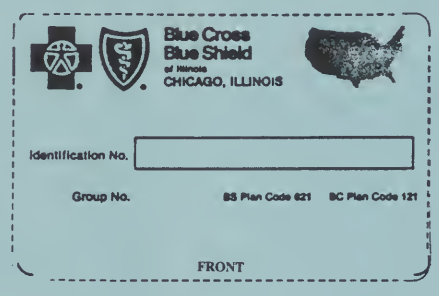
- Preadmission Review
- Second Surgical Opinion
- Concurrent Review and Discharge Planning
- Individual Benefit Management
- Employee Benefits Evaluation and Counseling

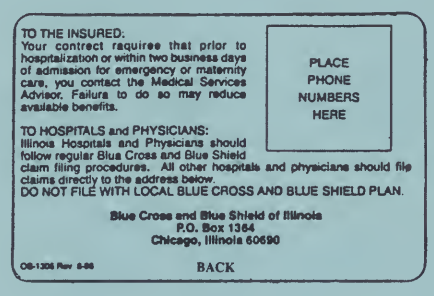
The preadmission certification process is an essential component of the MSA Program. Preadmission Review determines the appropriateness of setting and length of stay for a hospital admission or extended stay, but is not intended to replace the hospital's preadmission or concurrent review programs. The hospital's utilization review program, in conjunction with the attending physician, concurrently evaluates the patient's level of care requirements and facilitates a timely discharge.

Subscribers are required to contact the MSA prior to (1) all non-emergency inpatient (elective) admissions; (2) at the time of any non-elective admission; and (3) prior to rendering certain outpatient procedures designated by BCBSI for specific groups.

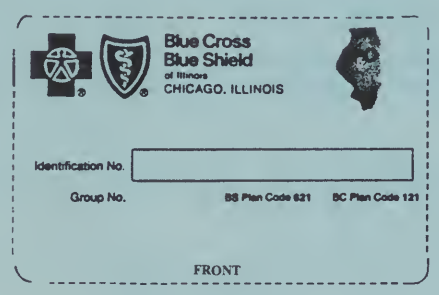
Below are examples of BCBSI standard insurance cards issued to subscribers with the MSA Program benefit. The phone number on the back of the card will put the subscriber or physician in contact with the Medical Services Advisor. Failure to contact the Medical Services Advisor will result in a reduction of benefits for hospital admission.

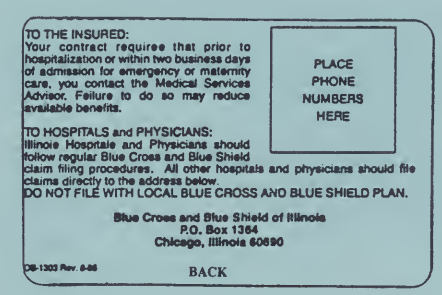
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Our standard Hospital Preferred Provider Program (PPO) includes the MSA program.

MSA preadmission authorization does not guarantee payment. Payment may be denied, or refunds requested from the hospital and the physician for non-acute care, medically unnecessary services or contract exclusions (i.e., diagnostic admissions).

If you have any questions regarding the MSA process, please call Terri Rotz, Manager, MSA at (312) 938-5838.

(This report is a service to the physicians of Illinois)
2/3/89

Editorials

AIDS prevention: No place for experiments

The mandatory premarital AIDS test law reached its first anniversary January 1, and now that the data are in, the jury is no longer out. Medical society and public health leaders who opposed this bill were right: broad spectrum testing of low risk groups is a poor place to allocate limited time and money. Acquired Immune Deficiency Syndrome (AIDS) prevention is a public health issue and that makes it a public education issue.

In 1987, the Illinois General Assembly passed a package of bills aimed at stemming the spread of AIDS. Legislators responding to constituent demands to "do something" supported some that were unproven, including a controversial measure requiring mandatory premarital testing. The premarital testing law went into effect January 1, 1988 and three months later, the ISMS House of Delegates called for its repeal.

This law creates an unnecessary burden on engaged couples. Illinois is the only state that requires it. The 160,000 premarital tests done in 1988 have yielded 23 AIDS cases. And many couples have fled to border states for their marriage licenses to avoid the requirement.

ISMS supports education and counseling on AIDS and its transmission to halt the spread of this terrible disease. AIDS is a deadly serious threat to the people of this state, and we must deploy our resources wisely in fighting it. This is no place for experimental mass screening programs.

The mandatory premarital AIDS testing law should be repealed.

Medical licensure: Keep standards high

The Illinois Department of Professional Regulation has promulgated rules to implement the 1987 Medical Practice Act licensing provisions and the 1988 improvements.

When Governor Thompson signed the medical malpractice tort reforms passed by the Illinois legislature in 1985, he issued a challenge to the medical profession. He called upon the medical community to improve medical discipline for practicing Illinois physicians and to enact stricter educational requirements for physicians seeking licensure in this state.

We met his challenge by participating in the Illinois Task Force on Medical Discipline, a blue-ribbon panel of physicians and state officials who worked many months to develop strong, specific recommendations to weed out incompetent and unethical medical practitioners. Their findings became the framework for the 1987 Medical Practice Act.

Some provisions of the new Medical Practice Act will be burdensome for some physicians. But we can't have it both ways. The law provides for enforcement of professional standards through its Medical Licensing Board and Medical Disciplinary Board. There, physicians appointed by the Governor work with Department staff to carry out the legal mandate. It is their responsibility to see that the law is equitably enforced and fairly administered.

The Illinois Medical Practice Act is not a perfect law. However, the major provisions were well thought-out by reasonable persons with good intentions. They shared one goal: to ensure a high standard of medical care to the patients of Illinois.

Illinois Medicine

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"If my beeper didn't go off, and your beeper didn't go off, whose beeper went off?"

Letters to the Editor

Letters for publication should be no longer than 300 words. All letters must be signed, and should be addressed to: Editor, Illinois Medicine, *Twenty North Michigan Ave., Suite 700, Chicago, IL 60602. The editors reserve the right to edit letters submitted for publication.*

A reader's review

I retired from a general surgical practice several years ago.

Sometimes I think I quit too early, but then when I peruse a practical/clinical journal such as yours, I realize how lucky I am.

I seem to have found your premier issue to contain two cruel hoaxes and two sick jokes.

Viz. page 1: "HMOs Weather the Storm" ignores their (HMO's) abject failure while their instigators—insurance companies, government and wily entrepreneurs—decimate yearly the private practice of medicine in America.

Page 4: "R B R V S" 2000 pages! (TWO THOUSAND?) and only 5 pages for the entire U.S. Constitution (with amendments!) What else needs to be said?

Page 6: "Case in Point" is a bad joke as well as a recurring nightmare to many physicians. The wrong doctor was sued.

Page 8: "Health Care Quality Improvement Act" simply promises more mischief. The only common sense was Judge McGarr's: "The HCQIA plants the feet of government firmly in the profession, and this is not good for the physician-patient relationship. It *HARMS* the quality of care." Incidentally HCQIA spelled backwards (AIQCH) is old Celtic for "ache".

Anyway, congratulations on your new periodical.

Eugene F. Dolehide, M.D.
Hinsdale

No longer calm

I read the insurance column by Edward T. Butt, Jr., J.D. ("For the Defense," 1/6/89). I realize he is on our side, but I do not agree that when citizens other than lawyers are abused by legal tactics and delays and cancellations we should forgive, forbear, keep calm, and listen to your lawyer. On the contrary, when I spend several hours reviewing my potential deposition and churn it over in my mind, while trying to fall asleep, I cannot keep calm and work with my lawyer, particularly when he doesn't show up.

My suggestion is what I asked my lawyer to do. When I was cancelled on two separate occasions, my attorney, at my request, had the judge deliver a court order on a date agreed upon by all parties. Everyone appeared. Further, this was the month of May. The attorney had said we had to meet before July, but the agreed-upon date was in October.

I conclude that some of the lawyers had no consideration for the preparation and my life arrangements.
Julius J. Wineberg, M.D
Waukegan

Mr. Butt replies:

I'm sorry that Dr. Wineberg had difficulties with the legal system. I assure him that I—and I hope all of my partners and associates—go out of our way to be considerate of the experts and consultants we retain. Moreover, I know that ISMIE does not look kindly upon having to pay consultants for time they have been inconvenienced. ▲

ISMS' lead helps to shape AMA/HCFA agreement

ILLINOIS PHYSICIANS and others who have worked to address medical necessity concerns in this state are reportedly "encouraged" by an agreement between the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) announced January 12.

The seven point agreement outlined in a letter from HCFA head William L. Roper, M.D. to AMA President James H. Sammons, M.D., will postpone for at least six months the AMA's threatened lawsuit to enjoin alleged arbitrary enforcement procedures causing "massive professional and patient problems."

Physicians here are most heartened by provisions calling for involvement of state medical societies when possible changes in medical coverage policies are under discussion. ISMS Board of Trustees Chairman Harold L. Jensen, M.D., pointed out that this progress can be attributed, at least in part, to activist measures already taken in Illinois.

"It was the Illinois delegation which introduced a resolution passed by the AMA House in June calling for repeal of the federal law permitting suspension or rejection of claims on the basis of medical necessity without physician peer review," Dr. Jensen said. "The AMA House also directed AMA leadership to explore potential judicial relief should neither legislative nor administrative relief materialize," he said.

Dr. Jensen pointed out that the Society, while acknowledging the AMA's role as "point man" in HCFA negotiations, had done its best to influence congressional decision-makers early on. "ISMS leaders contacted every member of the Illinois Congressional Delegation to outline objections to medical necessity provisions and suggest more acceptable terms," Dr. Jensen said. "There is little doubt but that these legislative contacts helped make HCFA more sensitive to medicine's concerns on this issue."

From theory to practice

Dr. Jensen observed that the AMA/HCFA agreement allows for state society input on global issues, but that the "proof of the pudding" will be in local physician experiences with HCFA's Part B intermediaries.

The AMA had used Illinois' "claim development letter" as a prototype in HCFA negotiations. "ISMS leaders have worked diligently with Illinois' Medicare Part B carrier on this issue," Dr. Jensen said. "We persuaded them to communicate with the treating physician first. This way, Illinois physicians have an opportunity to respond to charges that procedures fail to meet medical necessity screens."

Dr. Jensen explained that the claim development letter gives physicians an opportunity to attempt to resolve disparities by providing additional or clarifying material. "This has helped to reduce the number of unjustified refund/denial letters sent to Illinois patients," he said.

"ISMS actions alone could never fully resolve the problem in Illinois because Medicare is a federal program," Dr. Jensen said. "But we have made progress with the local carrier, and this latest development between HCFA and AMA is encouraging."

"I believe that our work has had a significant positive impact on the medically unnecessary refund/denial issue," Dr. Jensen concluded. "The Society will continue to push for publication of guidelines or specific, local criteria used in making medical necessity denials. We will also continue to work with the carrier and the AMA to improve Medicare claims processing policies and procedures." ▲

Obituaries

****Ahearn**
Dr. Thomas F. Ahearn, of La Grange, died June 29 1988, at the age of 81. Dr. Ahearn was a 1932 graduate of Loyola University Stritch School of Medicine, Maywood.

Hoppe
Dr. Jack W. Hoppe, of Danville, died June 5 1988, at the age of 66. Dr. Hoppe was a 1973 graduate of the College of Medicine, University of the East, Quezon City, the Philippines.

****Schonfeld**
Dr. Alexander Schonfeld of St. Louis, Missouri died April 24, 1987 at the age of 85. Dr. Schonfeld was a 1928 graduate of Charles Univerzita Fakulta of Ped-Gen Medicine, Praha, Czechoslovakia.

***Sokhey**
Dr. Baljit J. Sokhey of Orland Park died August 3, 1988 at the age of 56. Dr. Sokhey was a 1957 graduate of the Faculty of Medicine University of Rangoon, Rangoon, Burma.

****Stodsky**
Dr. Bernard Stodsky, of Chicago, died May 26, 1988, at the age of 76. Dr. Stodsky was a 1937 graduate of Rush Medical College, Chicago.

Tuthill
Dr. James H. Tuthill, of Barrington, died August 4, 1988, at the age of 59. Dr. Tuthill was a 1954 graduate of the University of Kansas School of Medicine, Kansas City.

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Exchange Q & A

Risk management manual available

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Q: Are newly-practicing physicians eligible for reduced insurance rates?
A: Yes. Reduced rates for the first 21 months are available to physicians beginning their practices. The newly-practicing physician rate slowly increases quarter-to-quarter until the premium reaches 100 percent. Newly-practicing physicians who may have had their premiums paid by employers for the first two years should realize that premiums may be significantly higher when they assume their own payments.

Q: How do I report changes in my practice activities to the Exchange?
A: It is the physician's responsibility to maintain his or her policy, even if another party, such as an employer, is paying the premium. Only the named insured may authorize a policy change. Reportable changes might include practice scope or location and hospital affiliation. The Exchange should be notified in writing in advance of any changes.

Q: What is the definition of a "part-time" rating?
A: Part-time ratings generally fall into three categories:

- A physician who can demonstrate reduced hours and patient volume may be considered for a 50 percent reduction of the quarterly premium. The Exchange gives each request careful and individual consideration. As with other policy changes, a part-time rating cannot be retroactive.
- A physician who has completely retired from practice, or a physician who has a medical practice insured elsewhere and who desires ISMIE coverage only for the occasional treatment of friends and relatives without remuneration may be considered for a 75 percent reduction in the quarterly premium.
- A resident who can demonstrate "moonlighting" activity of ten hours or less per week may be eligible for a 75 percent reduction in the quarterly premium. Residents whose "moonlighting" activity is 21 hours or less per week may be eligible for a 50 percent reduction in the quarterly premium.

Q: What is suspended coverage and when will it apply?
A: Suspended coverage is available to a physician who wishes to deactivate his or her policy for at least three months, but no longer than 12 months, for vacation, travel, continuing education, research, or other absence from active practice. In the case of incapacitating illness or disability, the policy may be suspended for a minimum of one month and a maximum of 12 months. The incapacitated physician needs a letter from his or her treating physician to reactivate the policy. ▲

REDUCING A physician's vulnerability to a malpractice lawsuit is often an exercise in professional behavior modification.

Effective risk reduction techniques are the subject of "Managing Your Risk: In The Office, At The Hospital," a new manual published by the Illinois State Medical Inter-Insurance Exchange (ISMIE).

"In the last few years, the threat of malpractice litigation has become an inescapable reality for all of us who practice medicine," ISMIE chairman Fred Z. White, M.D., writes, "But, while our growing vulnerability to lawsuits is a condition we need to acknowledge, it is not something we must accept. There are things we can do about it."

The manual and videotape are available to ISMIE policyholders. The videotape presents an overview of risk reduction techniques that can be used by physicians. The manual goes a step further.

It is a practical "how-to" that includes detailed explanations of the techniques, as well as sample forms that physicians can and should adapt for their own use. Both the videotape and the manual have been designed for use by the physician's entire staff.

Statistically speaking, there is a 1-in-5 chance a physician will be sued for malpractice each year. In addition, there is a nearly 50 percent chance that a physician is currently defending a negligence claim. Not only does this situation result in escalating insurance premiums, but often the task of defense results in deteriorating relationships with patients and a profound loss of self-esteem.

The manual points out that the physician can minimize risk by making special efforts to improve communication with patients, and by instituting effective patient management techniques.

Plaintiffs and their attorneys have said that the decision to sue is often at least partially influenced by a perception that the physician does not really care about the patient. Often this perception is primarily the result of poor communication with the patient. Poor communication in the office setting is manifested through a lack of friendliness or concern, failure to adequately explain a problem or procedure, inaccessibility, failure to inform a patient about the facts of an invasive procedure, inability or unwillingness to discuss a bad result, and a tendency to summarily make decisions without adequate patient consultation. Inadequate follow-up on a variety of matters—patient phone calls, missed appointments and extensive waiting time, referrals, test results, prescription refills, and discharge instructions—make matters worse.

In the hospital, poor communication can account for patient confusion resulting from consultation with specialists and the occasional differences of opinion that result from such consults. Patients can become alarmed by hospital gossip. Also, while the concept of informed consent or the possibility that a procedure may fail or produce complications may be second nature to most physicians, they precipitate a real fear of the unknown for the patient.

The manual offers detailed chapters on how to significantly improve patient communication in the office and at the hospital. Sections on developing a communicative attitude, techniques for achieving effective staff/patient communication, and minimizing the insecurity that patients feel in the hospital, illuminate the need for establishing a "spirit of friendliness and respect" that the patient picks up intuitively. Establishing and nurturing this spirit can count heavily in a patient's positive attitude about the physician, especially when things are not going well. Failure to do so, on the other hand, can cause equally negative feelings.

Effective risk reduction does not stop with improved patient communication. Patient management covers the entire realm of office activities to monitor the needs of each patient, from record keeping to scheduling, from test tracking to billing and collection. In the hospital, effective patient management means managing the healthcare team involved in a patient's care, while ensuring that comprehensive and accurate records are kept during the patient's hospital stay.

Both the videotape and the manual are currently available. Physicians who would like to borrow the videotape and/or acquire the manual, or have questions regarding risk management, are urged to contact the exchange at (312) 782-2749; 1-800-782-ISMS. ▲

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled the case?

Presenting complaint—Varicosity of the leg requiring surgery

Surgical outcome—Patient suffered cardiac arrest during surgery, sustained brain damage and subsequently died.

The case in brief—A 59-year-old man with a history of syncope and a possible earlier mild heart attack required surgery for a vein ligation of his right leg. An anesthesiologist administered the anesthetic and was present in the operating room during the surgery. Midway through the procedure, the patient suffered cardiac arrest, sustained severe brain damage and eventually died.

The resulting claim—Both the surgeon and the anesthesiologist were charged with failure to properly monitor the patient's anesthesia and vital signs during the surgery.

The outcome of the claim—The surgeon was not deemed liable but the anesthesiologist paid $500,000 to the deceased patient's family.

Why problems arose with this case—The anesthesiologist did fail to monitor the patient intra-operatively. Although there was no criticism of the care and treatment of the patient by the surgeon, confusion arose about the time at which the actual cardiac arrest occurred because the surgeon was tardy in dictating the surgical report. Other discrepancies in the medical records of the two physicians named in the claim also were found.

The point this case makes—Failure to monitor anesthesia properly is a repeated allegation in claims brought against anesthesiologists. Anesthesia should be regularly monitored and vital signs continually evaluated during any surgical procedure. The "Standards for Basic Intra-Operative Monitoring" approved by the American Society of Anesthesiologists should be observed as closely as possible to help assure quality patient care.

In addition, failure to maintain adequate, timely medical records is one of the major reasons that claims cannot be properly defended. If the medical record lacks the information needed to support the physician's assertion that the standard of care was met, it is extremely difficult to defend the case, even when the care provided is without fault. Anesthesiology records should be completed at the time of the procedure. Surgical records should be dictated in a timely fashion—within 30 days of a procedure, and preferably sooner. The longer the time lag between the surgery and the dictation of the record, the more likely that important information will be omitted. From a loss prevention standpoint, this is particularly important in the event that something goes wrong during the surgery that could eventually spawn a claim. In the event that a claim does go to trial, the lack of timely records could be damaging to credibility, especially in the eyes of the jury.

Records should be comprehensive. The chronology of events and actions taken when an unforeseen event occurs which could provoke litigation should be carefully noted in the record. It is important to remember that the quality of the medical record can be the deciding factor in whether the care rendered by the physician can be defended or not. Complete and accurate records are essential in successfully defending a medical liability claim. ▲

On the Legislative Scene

Lawmakers elect new leadership

JANUARY 10, 1989 marked the beginning of Illinois' 86th General Assembly session. Along with the pomp and circumstance of the members' swearing in ceremony, leaders were chosen to guide the legislature through the next two years.

Senator Phil Rock (D-Oak Park) was re-elected to his 6th consecutive two-year term. It took two ballots, but the Democratic majority successfully seated Rock in control of the Illinois Senate.

Senator Rock also announced the members who will serve the Senate as assistant majority leaders and caucus chairmen. Senator Vince Demuzio (D-Carlinville), Senator John D'Arco (D-Chicago), Senator Earlean Collins (D-Chicago), Senator Richard Luft (D-Pekin) and Senator Ted Lechowicz (D-Chicago) have all been chosen as assistant majority leaders. Senator Sam Vadalabene (D-Edwardsville) has been chosen to be Democrat caucus chairman.

In the House, Michael Madigan (D-Chicago) easily retained his position as speaker of the House. This will be his fourth term in that position. House Democratic leadership positions were also announced. Serving as majority leader for another term will be Representative Jim McPike (D-Madison). Assistant majority leaders re-named are Representative E. J. "Zeke" Giorgi (D-Rockford), Representative John Matijevich (D-Waukegan), and placed for the first time in House leadership are Representatives Bill Laurino (D-Chicago), Anthony Younge (D-Chicago), James Keane (D-Chicago) and Lovana Jones (D-Chicago). Majority whips for the session remain Representatives Peg Breslin (D-Ottawa) and Ralph Capparelli (D-Chicago). Representative Frank Giglio (D-Calumet City) was named conference chairman.

On the Republican side, Senator James "Pate" Philip (R-Addison) was re-elected as Senate minority leader. Named by Senator Philip as assistant minority leaders for the Republican party are Senator Aldo DeAngelis (R-Chicago Heights), Senator John Davidson (R-Springfield), and Senator Stanley Weaver (R-Urbana). Senator Adeline Geo-Karis (R-Zion) was named caucus chairman and Senator Jack Schaffer (R-Crystal Lake) was named minority whip.

Representative Lee A. Daniels (R-Elmhurst) was re-elected the House minority leader for the Republicans and will serve his fourth term.

Assistant minority leaders include Representatives Thomas Ewing (R-Pontiac), Gene Hoffman (R-Elmhurst), Penny Pullen (R-Park Ridge), and John Hallock (R-Rockford). Minority whips named are Representatives Robert Churchill (R-Antioch) and Michael Tate (R-Decatur). Representative Myron Olson (R-Dixon) was named conference chairman. ▲

AIDS test

(continued from page 1)

Schafer, the Department's budget for AIDS testing, counseling and education programs is about $7 million, which is roughly split between state and federal sources.

Couples flee state for licenses

Many couples crossed the border to Wisconsin and Indiana to avoid the premarital AIDS screening test. The Wisconsin's Kenosha county clerk's office said that it issued 1,142 marriage licenses to Illinois residents last year—up from 58 in 1987. And in Indiana's Lake County, 1,008 licenses were issued, a six-fold increase over the 167 in 1987.

Public health's projections amount to a 19% decrease in marriage licenses issued—and resulting loss of $288,000 in licensure fees to county coffers.

Legislative proposals pending

Ellis P. Levin (D-Chicago) and Grace Mary Stern (R-Highland) have introduced separate bills in the Illinois House to repeal the Illinois premarital AIDS test. Levin's bill would suspend requirements for both AIDS and syphilis screening; Stern's is limited to an AIDS test repeal.

Illinois is the only state with a premarital AIDS screening test requirement. Illinois Governor James R. Thompson expects a status report from IDPH early this year, according to Schafer, and IDPH Director Bernard Turnock, M.D., will be strongly behind repeal. "Dr. Turnock intends to recommend that the law be repealed because it is directed to a low-risk group and because there are more efficient ways to identify people who may be at risk," Schafer said. Dr. Turnock has opposed the law from the outset.

Illinois State Medical Society policy adopted in April 1988 opposes premarital HIV testing. The Society has since been publicly committed to the repeal of the premarital screening test law. ▲

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Medical Indigency

continued from page 1

of Illinois' two southernmost counties, Alexander and Pulaski, must travel 40 miles to Carbondale to reach an Illinois hospital.

Community clinics see more traffic

Fred Bernstein is the executive director of Community Health and Emergency Service, Inc., which operates a community health center in Cairo plus a satellite office to serve the approximately 20,000 people living in Alexander and Pulaski counties. The poverty-stricken area has had an unemployment rate of more than 20 percent for about 10½ years, Bernstein said. The Community Health patients reflect this; many pay at some level in a sliding fee.

John A. Carroll, M.D., of St. Francis Hospital in Peoria spends part of his time at St. Francis working in the hospital's community clinic, which has been in operation for some 40 years. In addition to the clinic, the hospital also has a satellite office in a local housing project.



John A. Carroll, M.D., St. Francis Hospital, Peoria: $5 clinic fee helps protect patients' self respect.

Dr. Carroll estimated that the clinic serves about 4,000 to 5,000 people, which includes both those on public aid and those who don't qualify for public aid but whose incomes fall under a certain level and who are usually uninsured or underinsured. The clinic, supported in part by the United Way, charges its patients $5 per visit. ("We charge it, but we don't demand it," he said.) The fee includes the office visit and any x-rays or lab work. Dr. Carroll said that paying the fee "helps protect a patient's respect for himself."

Drs. Carroll and Bernstein agree that while community clinics make health care more accessible for the medically indigent, primary care is more than a question of affordability. Transportation and education might play a part. Some patients without insurance are uncomfortable about accessing the health care system and will postpone care until their need is emergent. Both cited a frequent lack of prenatal care; Bernstein said that they frequently do not see women until their 34th or 35th week of pregnancy.

Sometimes the medically indigent use emergency rooms as primary care centers. Bernstein said that after the local Cairo hospital closed in 1986, their health care office operated a state-funded emergency care facility for 18 months where he said they saw a high number of non-

Pulling together

Will-Grundy clinic marshalls community forces

by Judy Alsofrom

UNEMPLOYMENT IN the Will-Grundy counties peaked at 24% in the early 1980s, and recently flattened to about 10%. Many of those who make up these percentages do not qualify for Medicaid. They definitely can't afford insurance.

What do they do for medical care?

Until recently, literally nothing.

One woman who came into the new Will-Grundy Medical Clinic, Inc., in Joliet, complained of back pain. The physician taking her history discovered that she was a diabetic who had been without insulin for three weeks because she could not afford to buy any.

One gentleman visiting the clinic had a lesion on his nose for a long time. He came in saying he knew it was cancer, but he couldn't pay a doctor to do anything about it. He was right about the lesion. It was a basal cell carcinoma.

He was wrong about his options for medical care. The Will-Grundy Clinic and the Will-Grundy community took care of it.

At an awards dinner held in November, 1988 to honor the physicians and other volunteers who have donated their services and energy to provide much-needed care to the community, American Medical Association (AMA) President James E. Davis, M.D., said, "Millions of Americans deserve it, need it, and truly aren't getting it—the kind of care you're providing here in Joliet."

That care, the care given to the woman with back pain and sent home with a free supply of insulin and to the gentleman who needed $400 worth of surgery and received it for free, was a long time in the making, recalled anesthesiologist Albert W. Ray, Jr., M.D., a member of the clinic's medical advisory board.

"In 1975, we [the physician-members of the Will-Grundy County Medical Society] had a rotating assignment mechanism [for patients who couldn't pay], and doctors would say, 'I'll take so many patients a month.' "



Mark Sinibaldi, M.D., president, Will Grundy County Medical Society (center) presented the Society's 1988 public service award to Frank Laule, president, Will-Grundy Medical Clinic board of directors (L) and Mrs. Elaine Griffin (R)

"But the assignment need was so great, the assignment mechanism became more of a deterrent—not an advantage. We threw it out.

"We then tried a clinic for these patients at each hospital, but as the rates went up and the referral mechanisms [bogged down], it was decided that there was no way physicians could provide all the care that was needed without the help of the community," Dr. Ray said.

Where it all began

In January of 1985, the newly installed Will-Grundy president, Theodore M. Kanellakes, M.D., urged the Board of Directors to establish the access problem as one of the society's major priorities. Gradually, through a process that involved scores of meetings and hundreds of hours of debate and discussion, it was decided that the best solution to the problem would be the establishment of a clinic, to be staffed by physician volunteers. As this concept was studied, however, it became evident that the medical society lacked the resources to establish a clinic on its own.



AMA President James E. Davis, M.D., praised the physician and community leadership required to establish the clinic.



Theodore M. Kanellakes, M.D., 1985 president of the Will Grundy County Medical Society, who spearheaded efforts to improve access to care for the needy. Dr. Kanellakes has continued to play a leadership role, serving on the clinic's board and its medical services advisory committee.

"In 1986, we went to the community and said, 'we'll provide the medical support, but you've got to provide the business support, religious support, community support, and transportation,' " Dr. Ray said.

During the months which followed and through 1987, the physicians and community representatives worked together. A not-for-profit corporation was formed. Subcommittees were created and assigned specific tasks.

Meanwhile, Dr. Kanellakes led an internal campaign to recruit physician volunteers. Doctors were asked to staff clinic sessions or accept referrals from the clinic, depending on their specialties.

Months of study indicated that a free clinic staffed by volunteers and a rotating group of volunteer physicians was the route to providing primary, diagnostic, and therapeutic care to the patients in Will and Grundy counties "who fall through the cracks," physicians said.

It took about a year to find a suitable site, train staff and stock the clinic. Almost all material, serv-

emergency cases. Other medically indigent persons attempt to skip primary care altogether. For people who lost their health insurance when the plant they worked at closed, for example, the problem of accessing medical care might be psychological, suggested Ron Damasauskas, vice president of professional affairs for the Illinois Hospital Association.

"It's difficult for them to ask for care they can't pay for," he said.

George O'Neill, executive director of Shawnee Health Service and Development, said that in the past 18 months there's been a 25 percent drop in patients who carry health insurance in the 13 Illinois counties served by the Shawnee network. The network includes health centers in Murphysboro and Carterville, an adolescent health center, four respiratory disease diagnostic and treatment centers, and a homebound program for people over 65.

In Chicago, the Chicago Department of Public Health's network of outpatient clinics care for 150,000 medically indigent patients a year, and all health care providers that offer free or low-cost care are operating at 100 percent capacity, according to Patrick Lenihan, deputy commissioner.

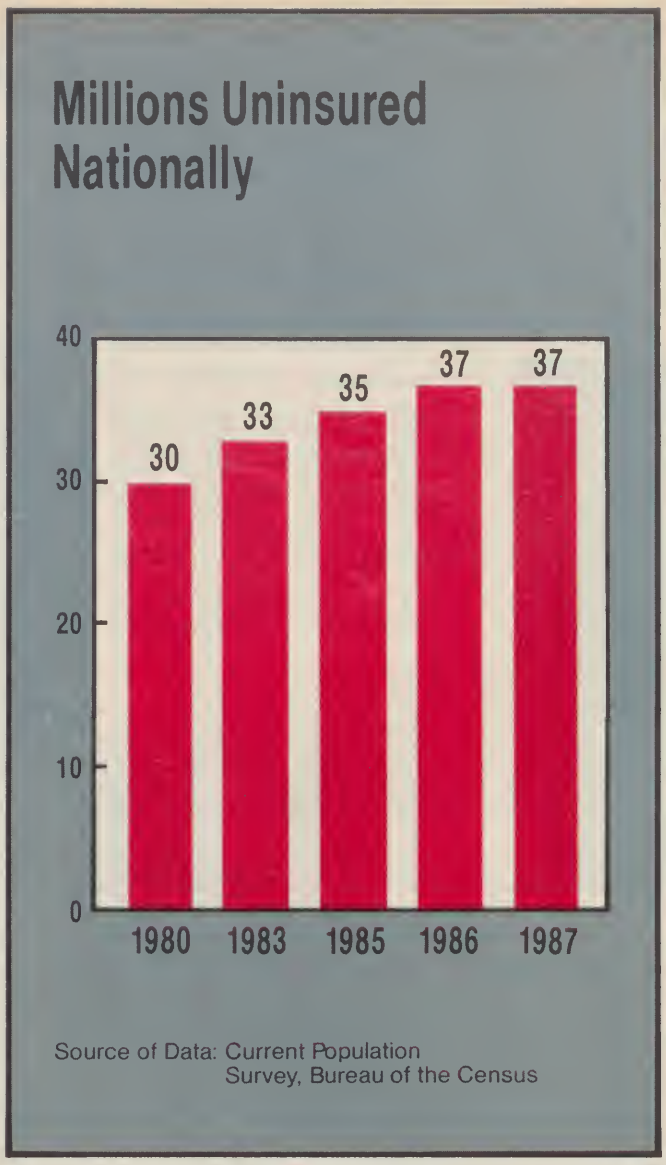
"There's no strong indication that the problem is growing," he said, "but it's certainly not abating."

Front liners not optimistic

A number of factors have contributed to the growth of the medically indigent population, and those grappling first-hand see no simple solutions.

Sacred Heart's Novak points out that the "aging of America" will mean less employer-provided insurance and further burden the Medicare program. The Chicago Health Department's Lenihan is troubled by the continuing shift from a manufacturing to a service economy. Service jobs traditionally pay less, he observes, and are less likely to offer health insurance.

And while those providing care to the medically indigent have traditionally balanced the cost of providing this care by shifting the burden to those who can pay, third party payers are no longer willing to pick up these costs. Lenihan noted that insurance companies and health maintenance organizations have begun to negotiate rates with hospitals and other health care providers—as have state and federal public assistance agencies. This means that hospitals are increasingly left shouldering the costs themselves. With the medically indigent many times postponing care until they are so sick they end up in a hospital emergency room, this means even higher health care costs.



Some patients without insurance are uncomfortable about accessing the health care system and will postpone care until their need is emergent.

Cost problems are compounded for small businesses, which employ a disproportionate amount of the very young and the very old. According to Landrum, many small businesses have been priced out of the health insurance market.

The high rate of failure for small businesses makes them a poor insurance risk, said Pam Mitroff of the Illinois State Chamber of Commerce. Mitroff, manager of health care cost management, said that the high turnover rates in small companies contribute to the administrative costs of offering insurance. And both federal and state laws now require companies to offer departing employees the option of continuing their coverage, she said, which can be costly.

Society commits to leadership role

Medical indigency was a subject for discussion when the Illinois State Medical Society (ISMS) Board of Trustees met on January 21 in the Society's Chicago offices. According to Board Chairman Harold L. Jensen, M.D., Harvey, trustees across the state are committed to "the less glamorous spadework" which they believe is the only route to a genuine solution.

"Medical indigency is a fundamental access problem of the uninsured and the underinsured," Dr. Jensen said. "The causes are multifaceted. They reach to some of the most complex and frustrating troubles confronting our health care system. We might be tempted to attach a financial band-aid to medical indigency in Illinois, but it's not that simple."

Dr. Jensen said that the Board had empowered the Society's leadership to pursue cooperative efforts with other interested groups to shed light on Illinois' medical indigency problem. "We have made an affirmative commitment to work toward access to medical care for all who need it," Dr. Jensen said. ▲

ices, labor, and equipment was donated.

Pharmaceutical firms and doctors contribute medications for on-site use, and other prescriptions are filled by local pharmacies at cost and are paid for with donated funds.

And there are only two paid positions: one part-time executive director and one part-time director of nursing.

Just what makes this clinic, opened in March, 1988, work?

E. David Griffin, M.D., is a local pediatrician who acts as a primary physician to all ages when he is on clinic grounds. Dr. Griffin paid homage to his wife Elaine (honored at the dinner), who works diligently for the clinic as do many of the physicians' wives in the counties, and to the local hospitals, Joliet's St. Joseph's Hospital and Silver Cross Hospital, which provide rooms and ancillary services at no charge.

Physician leadership is clearly key. While Dr. Griffin is happy to do the routine school physicals during his day at the clinic, it's the bow legs that he hasn't seen since his days at Cook County Hospital—bow legs due to rickets—that keep his commitment taut. Because the response has been so great from the local physicians, the time commitment runs to just once a month at the clinic, Dr. Griffin adds.

A tremendous spirit of cooperation and the local word-of-mouth keep the clinic going, as it is always in need of funds and supplies for the average patient who is uninsured and unemployed.

Patients are asked for a $5 donation, but no one is ever denied care if they lack the contribution, and the care is the same as if the physician were treating a private patient. Dr. Kanellakes is an allergist. He goes down to the clinic as a primary care physician, but for those who have asthma or hay fever, hives, drug allergies, or allergic skin disorders, his office is open. "It's easier for the clinic to refer the patients directly to me," Dr. Kanellakes says, rather than to transport his personnel and testing equipment to the clinic.

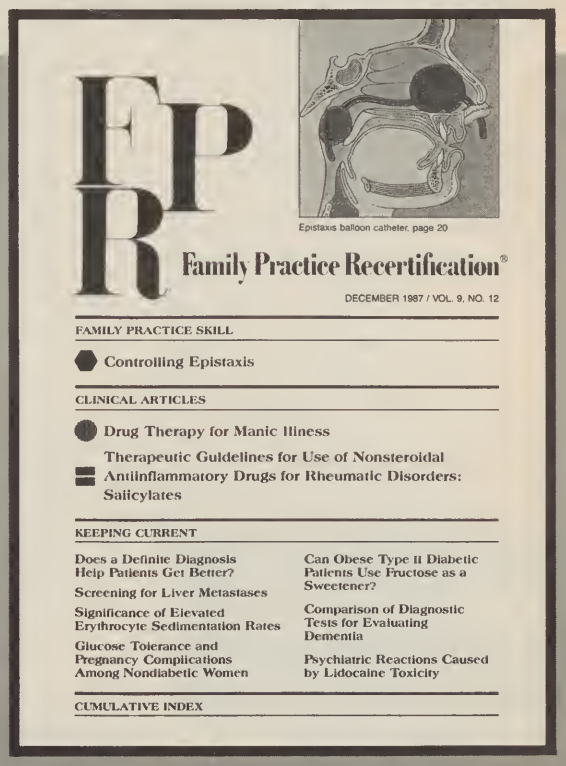
The clinic is open five days a week with doctors' hours held Tuesday and Thursday. There is a roster of 84 volunteer physicians and dentists. ▲

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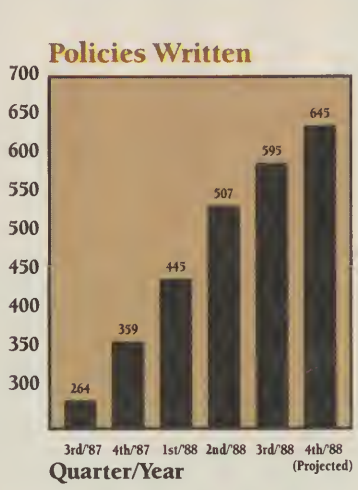
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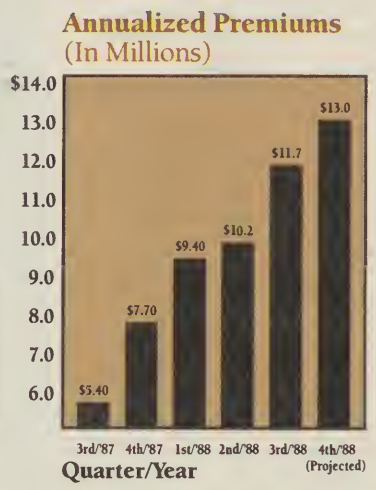
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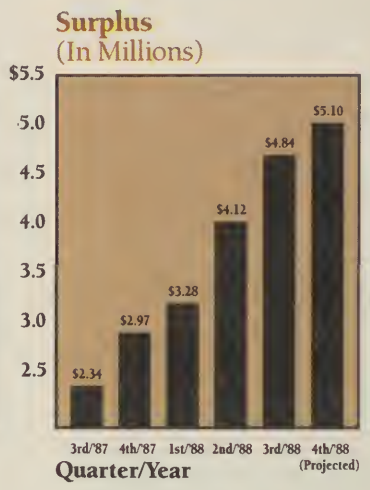
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Colocolic intussusception: A rare clinical entity

by Lee N. Dennis, M.D., Ronald B. Port, M.D., Milton L. Paige, M.D., and Joseph O. Sherman, M.D./Evanston

Editor's Note: This clinical manuscript was initially accepted by the physician editorial board for publication in the Illinois Medical Journal.

Intussusception is one of the most common causes of intestinal obstruction in young children. The colocolic variety occurs rarely. This report describes the clinical and radiological findings in a four-month-old patient with this uncommon type of intussusception.

Intussusception is primarily a disorder of infants, with the majority of cases beginning at or near the ileocecal valve.[1] Several studies have demonstrated that between 75%-85% of intussusceptions in children are ileocolic, followed in number by ileoileal.[2,3] Little has been written in U.S. radiologic literature concerning colocolic intussusceptions in children. Various reports from North American institutions note the incidence of colocolic intussusceptions to be from 2.1%-5%.[3,4]

Case report

A four-month-old white male with an unremarkable history began vomiting formula on the morning of admission. He had screaming episodes in the early afternoon and began passing dark-red stool.

On admission the patient's vital signs included a rectal temperature of 98.3° F, pulse 100, blood pressure 84/50, and respirations of 28/min. Physical examination was remarkable for a diffusely tender abdomen without rebound. A left lower quadrant sausage-shaped mass was palpated. Rectal examination revealed grossly bloody stool and a large nonprolapsing rectal mass. Pertinent laboratory values included a hematocrit of 35.2% and a white blood cell count of 17,700 with 64% segmented neutrophils.

An intussusception was diagnosed, and a barium enema was performed. No abdominal films were obtained. The patient was sedated with 6mg of meperidine intramuscularly before the enema was performed. When barium was introduced into the rectum, a mass lesion was encountered approximately 3cm from the anal verge. The mass extended at least 18cm proximally and had the appearance of an intussusception. (Figure 1) The intussusception was unable to be reduced by hydrostatic pressure, and the patient was taken to surgery.

At surgery, a colocolic intussusception was encountered in the left colon with marked dilatation of the ascending and transverse colon. (Figure 2) The intussusception was manually reduced, and the involved colon was judged viable; there was no obvious lead point. A follow-up barium enema was performed four weeks later and no abnormalities were noted.



Figure 1 Barium enema showing the left-sided colocolic intussusception with complete obstruction.

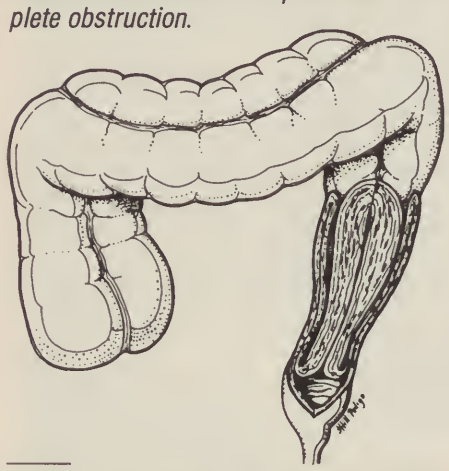


Figure 2 Diagramatic illustration of the colon at operation. Note the dilated ascending and transverse colon proximal to intussuscepted bowel.

Discussion

The majority of pediatric intussusceptions are ileocolic. Little has been written in the North American literature concerning the uncommon colocolic intussusception, although one report noted a colocolic intussusception with broad-based colonic polyps as the lead point. The presentation led to the diagnosis of Peutz-Jeghers Syndrome.[5] These authors suggest that polyposis be considered in the infant with such atypical intussusception. Ippolito and Touloukian note that of 33 colocolic intussusceptions reported in the English language literature, juvenile polyps were found as lead points in nine cases (28%) and the remaining 24 cases were without organic lesions.[4] Leading points are found in 2%-8% of pediatric intussusceptions,[1] and the presence of a juvenile polyp should be suspected in patients with colocolic intussusception.[4]

In contrast to the rarity with which colonic intussusceptions are encountered in North America and Europe,[6] there is a high incidence of primary colonic intussusceptions in infants and children in Africa.[7] Davies and Cywes note that of 197 patients over an eight-year period, 37 (19%) had colonic intussusceptions. They further categorized these intussusceptions into (1) cecocolic (total of 16); (2) colocolic (total of 13); and (3) sigmoidrectal (total of 8). At present, the reason for the difference in the prevalence of colonic intussusception between North America and Europe compared to Africa is unknown. Interestingly, 9 of the 16 patients with cecocolic intussusception in the series of Davies and Cywes harbored *Ascaris lumbricoides*.

Summary

We have presented a case of idiopathic colocolic intussusception in a four-month-old child which, to our knowledge, is rarely seen in North America. There is a recognized racial and continental difference in the type of intussusception encountered,[8] which should be considered by the clinician and radiologist. ▲

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Lee N. Dennis, M.D., *was chief resident in the department of diagnostic radiology, Northwestern University Medical School at this writing. He is a member of the Radiologic Society of North America and the American College of Radiology.*

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(continued from page 3)

IM: Whose responsibility is it to apply for a temporary license?
DPR: The Department of Professional Regulation is authorized to license *individuals*, not residency programs. Therefore, the legal onus for obtaining a license rests with the individual applicant. Medical residents are not allowed to practice medicine without a license, which is why residency program officials should advise prospective residents to apply well before the 60 day deadline. Program directors might also monitor applicants' progress in this regard.

IM: What other factors can delay the processing of an application?
DPR: Incomplete applications are the primary reason for delay. Applicants should gather and submit required documents in a timely manner. Applications without solid evidence that the two year clinical core rotation training occurred in a program formally affiliated with their medical school will be subject to MLB review. Affirmative answers to questions regarding personal history (*e.g.*, prior felony convictions, previous license revocation, past drug or alcohol abuse) will likewise delay applications. Name changes, or hyphenated names not consistently listed on all documents, can further delay the process.

IM: You've already indicated that applicants who graduated from medical school before 1985 will have their applications reviewed by the MLB. What will this process entail?
DPR: Pre-1985 medical graduates not previously licensed in another jurisdiction will first be required to submit complete applications, including assurance that the applicant will be accepted into a residency program upon receipt of a temporary license. Once their applications have been completed, they will be required to appear at an interview with a member of the MLB to describe how they have maintained their clinical skills. The review process for pre-1985 graduates will be longer than for most other applicants, and pre-1985 graduates are encouraged to submit complete applications as soon as possible.

IM: Where and when will these interviews take place?
DPR: The dates and times of the interviews will be subject to availability of MLB board members. Interviews will be scheduled for either Springfield or Chicago. Those applicants whose materials are completed early, and who desire to complete the interview process quickly, may be asked to come to Springfield.

IM: What will be the objective of the interview?
DPR: The interview is structured to assess the clinical skills of the applicant. The board will be exploring how the applicant has maintained clinical skills between the time of graduation from medical school and application for a license.

IM: What kinds of things will the board consider in clinical skills assessment?
DPR: The proposed rules state that the MLB may consider a number of factors when determining continuing clinical skills. For example, documentation of human clinical research that is consistent with requirements of the federal Food and Drug Administration, specialized clinical training or education in recognized residency programs and post-graduate education in basic or related medical sciences are eligible activities. Continuing medical education (CME) accredited by the Accreditation Council on Continuing Medical Education (ACCME) or other recognized entities is also weighed. Clinical research or clinical medical practice in the National Health Service, other public health organizations (*e.g.* World Health Organization), or at a veteran's, military or other federally operated medical institution, may be considered.

Applicants may also demonstrate continuing clinical skills by submitting evidence of publication of original work in clinical medicine appearing in journals listed in *Index Medicus*; presentation of papers or participation on panels for programs approved by the American Medical Association, American Osteopathic Association, or specialty societies; or experience obtained as a visiting professor as defined by Section 18(A) of the Medical Practice Act.

Finally, applicants should note that clinical medical practice obtained in violation of the Act is clearly ineligible. Such documentation would indicate that the applicant had been practicing medicine without a license.

IM: Who will be present during the interview?
DPR: As it stands now, the applicant, a department attorney, possibly a department staff person, and a board member. Applicants may also bring an attorney if they desire.

IM: What will the interview be like and what will happen after the interview?
DPR: It will be a very informal discussion lasting about an hour focusing on the maintenance of clinical skills. After the interview, the board member will make a recommendation to the full board to either grant or deny a license.

IM: Can applications from previous years be used in 1989?
DPR: No. The changes in the Medical Practice Act have caused significant revision of the application materials. The instructions for completing the application have been totally revised, as has the certification of education form and the certification of acceptance into the residency program form.

IM: Will it take longer to complete the application as a result of these revisions?
DPR: Quite possibly. For example, the Department no longer will be able to verify completion of the final four years of the six-year post-secondary education (*i.e.*, the two academic years in the basic sciences and the two-year clinical core rotation) from transcripts. The vehicle for verifying this information will be a new certification of education form, which applicants will have to submit to their medical schools for completion. Even though the school will then return the form directly to the state, applicants should plan accordingly.

However, if an applicant possesses *original* documents that substantiate the completion of the final four years of six-year post-secondary education, the Department will accept those documents. Also, transcripts will be acceptable to verify the first two years of the six-year post-secondary training (*i.e.*, the two years of liberal arts education) as long as the transcript verifies two nine-month academic years.

IM: When will the applications be available?
DPR: Application for both permanent and temporary licenses should be available mid-February.

IM: Are there materials that applicants can be collecting now in anticipation of receipt of the application forms?
DPR: Yes. They can begin gathering their college transcripts, which will still be required. Applicants should ensure that the transcripts show complete dates and include an official translation, if pertinent. They can acquire their ECFMG certificate, their affiliation agreement; and all documentation showing that their clerkships were completed in no less than four weeks and no more than twelve weeks. In addition, they must have a completed evaluation form for each clerkship. Documentation authenticating possible name changes should be acquired. Finally, pre-1985 medical graduates should begin collecting documents to substantiate maintenance of clinical skills.

IM: There has traditionally been a training session on the use of new applications for assistants to residency program directors. Will there be such a training

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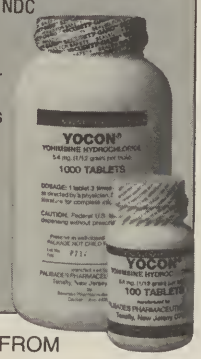
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session this year?
DPR: Yes. Current plans call for a training session to be held in the latter part of February. Residency program officials will be notified by mail of the date, place and time of the training session. In addition, it is anticipated that the proposed rules regarding pre-1985 medical school graduates will be explained at the training session.

IM: If a medical graduate is accepted into a residency program that is scheduled to begin on July 1, but a delayed temporary license application causes the granting of a license after July 1, can the resident commence the program on July 1?
DPR: No. The Medical Practice Act explicitly prohibits the practice of medicine without a valid Illinois license. From the Department's perspective, the applicant is licensed to practice medicine on the date that the hospital receives the temporary license. A resident who begins training prior to the granting of a temporary license *could* be considered to be practicing without a license. Moreover, residency program directors who permit residents to begin training before the hospital has received the temporary license will be held liable.

IM: Residents whose applications have been delayed beyond the contractually specified date have been known to begin their training anyway, justifying their action by saying that failure to do so would have resulted in forfeiture of their place in the program. Similarly, some residency program directors have expressed concern that the failure of residents to begin training on the contractually specified date would place the residency program directors in breach of contract. What is the Department's position on this?
DPR: The Department reiterates that beginning one's training without first possessing a valid Illinois license constitutes the unlicensed practice of medicine. Any such incidents that come to the attention of the Department will be investigated. In such instances, it is Department policy to look up the facility's chain of command for the official (*i.e.*, residency program director) approving the beginning of the training. Such officials should know that they too will be held liable along with the resident who began training without a license.

The breach of contract issue is actually outside the Department's jurisdiction and, consequently, the Department has no official position. Therefore, the Department strongly urges residency program directors to consult with their institutional attorneys regarding this concern. One possible option is inserting a provision in the resident's contract stating that the contract is valid contingent upon the granting of a temporary license.

IM: Can residents who are in attendance on July 1, 1989, but, because their temporary license was delayed until August 1, 1989, did not begin their formal post-graduate training until August 1, 1989, be certified for permanent licensure on July 1, 1991?
DPR: No. State law requires that all residents complete 24 full months of post-graduate training. Therefore, a resident who is in attendance on July 1, 1989, but, due to the lack of a valid temporary license, does not begin formal post-graduate training until August 1, 1989, must be in training until at least July 31, 1991 before being certified for permanent licensure.

IM: What other tips can facilitate this process?
DPR: Applications should be mailed to Pat Eubanks in the Medical Section of the Department of Professional Regulation in Springfield. Use regular mail only; do *not* use express or overnight mail. Express and overnight mail must be logged and routed to the proper department, so it does not expedite the handling process. Nor should applicants personally bring in their applications. Their applications must go through the proper review process, so applicants will not receive an answer the day they bring their applications in. Moreover, the applications have to be routed to the proper office, so they might as well mail them to begin with.

Finally, residency program directors should designate one individual in their office to communicate with the Department on the status of applications, and discourage other members of the hospital's medical staff and applicants from telephoning the Department regarding the status of individual applications.

IM: When do the new rules pertaining to pre-1985 graduates become effective?
DPR: The proposed rules were also submitted as emergency rules on January 1. Thus, the rules are currently in force. However, there is a 150-day review period from the date that they were published in the Illinois Register, which was January 13, before they are formally adopted.

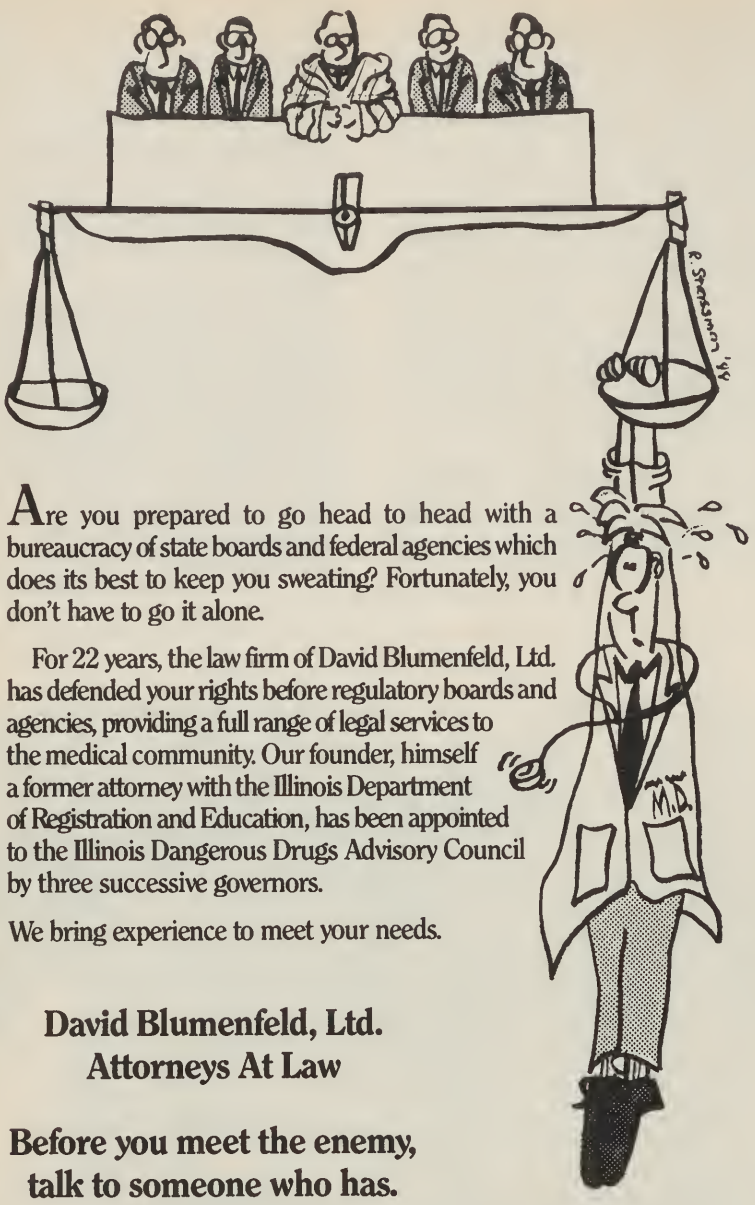
IM: Is there a period for public comment on the proposed rules for pre-1985 graduates?
DPR: Yes. Interested persons have 30 days from the date the rules were published in the Illinois Register, (or until February 12) to comment. Written comments should be sent to the Department of Professional Regulation; Attention: Jean A. Courtney; 320 West Washington; 3rd Floor; Springfield, IL 62786. ▲



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News Capsules

Members in the News

The American College of Surgeons Commission on Cancer recently appointed **Mehmet Sipahi, M.D.,** Riverside Medical Center, Kankakee, and **Lloyd F. Walk, M.D.,** St. Elizabeth's Hospital, Belleville, to three-year terms as cancer liaison physician for their respective programs. . . . **Edwin Mullin, M.D.,** Manlius, received a proclamation in honor of his 43 years of "country doctoring" from the Illinois General Assembly last October. . . . **Elvin Zook, M.D.,** Springfield, has been elected secretary of the American Society of Plastic and Reconstructive Surgeons, Inc. Dr. Zook is professor and chairman, division of plastic surgery at Southern Illinois University School of Medicine.

James W. Marshall, M.D., Monmouth, was recently honored and awarded a plaque for his years of service to Monmouth College. Dr. Marshall, a 1936 graduate of Monmouth, served the college as a physician from 1948 to 1973 and as a member of the college senate. He received the College's Distinguished Service Award in 1977.

Lawrence Hirsch, M.D., Northbrook, has been reelected chairman of the Illinois Department of Professional Regulation (DPR) Medical Licensing Board, and **Robert L. Hambrick, D.O.,** Chicago will chair the DPR Medical Disciplinary Board.

Armenian Earthquake Relief Efforts Organized

Naperville physician **George G. Markarian, M.D.** is leading local efforts to collect supplies to aid victims of the Armenian earthquake last month. Those supplies which are most needed include pain medications, antibiotics, and IV fluids, tubing and needles. Physicians wishing to make contributions should contact Dr. Markarian's office at (312) 366-3774 or the DuPage County Medical Society at (312) 858-9603.

Meetings and Announcements

The Illinois Hospital Medical Staff Section fourth annual meeting will be held Saturday, February 18, 1989 from 9:00 a.m. to 4:00 p.m. at the Westin O'Hare Hotel, 6100 N. River Road, Rosemont. A complete schedule of events and speakers can be obtained through the ISMS offices.

Effective February 6, 1989 the Illinois Academy of Family Physicians will be located at: 650 Woodfield Drive, Suite 730, Schaumburg 60173. The phone numbers are: (312) 240-5522, 1-800-826-7944 (in Illinois). ▲

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Governor James R. Thompson

Governor targets drug abuse and medical indigency

by Kevin O'Brien

GOVERNOR THOMPSON proposed funding a $50 million attack on Illinois' drug abuse problem with a new 18-cent-per-pack increase in the state cigarette tax in his 13th State of the State message two weeks ago.

He also voiced support for the state's current Comprehensive Health Insurance Program (CHIP), and promised to develop a long-term program to guarantee access to health care for 1.5 million currently uninsured Illinois citizens.

Bolstering his case for expanded drug abuse programs, Gov. Thompson cited U.S. Justice Department figures showing that three out every four people arrested for violent crimes in Chicago tested positively for drugs. Illinois court system statistics reveal that only six percent of the more than 17,000 adults on probation who need drug treatment actually get it, he said.

Gov. Thompson said that with increased drug abuse revenues, the

(continued on page 2)

Clean indoor air bill revived

by Kevin O'Brien

SAYING THAT all Illinois citizens are entitled to a clean environment, Representative Robert Terzich (D-Chicago) has again introduced a measure in the Illinois General Assembly to prohibit smoking in public places.

"People appreciate the fact that smoking is the leading indoor polluter," Terzich said. The Illinois Clean Indoor Air Act would prohibit smoking in public places except in specially designated smoking areas. The measure exempts most taverns, hotels, public rooms used for private functions, factories, and workplaces exclusively inhabited by non-smokers.

Terzich has introduced similar bills for at least the last three years. A measure virtually identical to the one just introduced failed last spring by one vote in the House Executive Committee, despite support from several medical groups, including ISMS.

State Senator Bob Kustra (R-Des Plaines) said that he will introduce a companion bill in the Senate early next month. Kustra was the Senate sponsor last term as well.

Last month, Illinois Department of Public Health Director Bernard Turnock, M.D., citing IDPH figures that show smoking kills more than 15,000 Illinois residents each year and costs the state $2.8 billion annually, called for passage of the bill.

"The Surgeon General has called cigarette smoking the chief preventable cause of death in the United States," Dr. Turnock said at a Chicago news conference. "The time has come for a state law to protect nonsmokers from such risks and to encourage smokers to try to break a habit that can be deadly."

Joining Dr. Turnock in boosting passage were representatives of the U.S. Public Health Service, the American Cancer Society, the Chicago Lung Association, the Illinois Cancer Council, the American Heart Association of Metropolitan Chicago, and the Interagency Council for a Tobacco-Free Society.

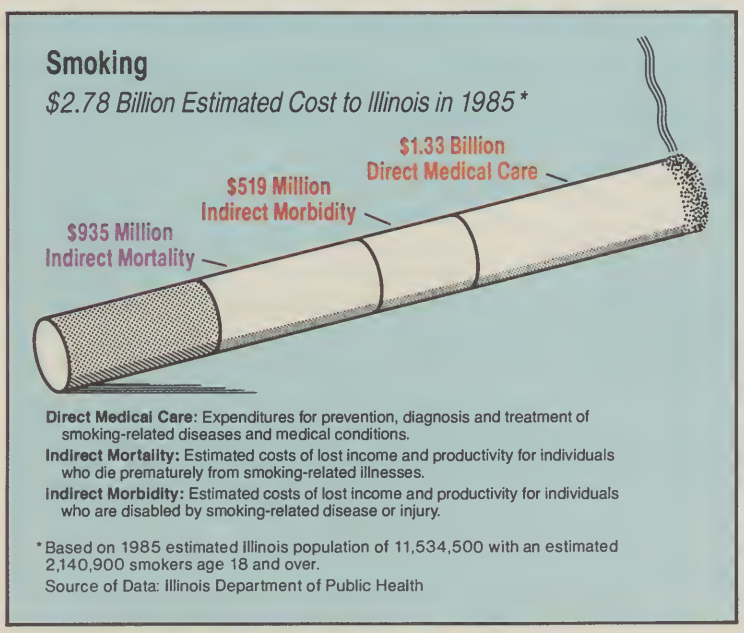
Dr. Turnock said that 15,669 Illinoisans died in 1985 from lung and other cancers attributed to smoking, as well as from heart disease, respiratory and other illnesses directly related to smoking. (1985 is the last year for which complete figures are available.)

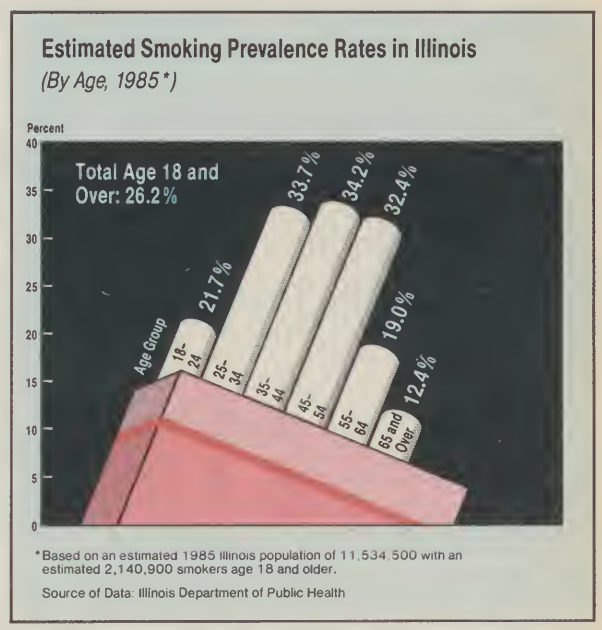
The IDPH total includes 4,271 lung cancer deaths, 4,012 from heart disease, 3,047 from respiratory diseases, and 2,664 from other cardiovascular diseases. The remaining 1,675 people died from other smoking-attributable causes.

The $2.8 billion annual price tag reflects prevention, diagnosis and treatment costs, as well as lost income and lost productivity for individuals who die prematurely or suffer smoking-related disabilities. Dr. Turnock said this is equivalent to $1.97 for every package of cigarettes sold in the state.

He said that based on an estimated 1985 Illinois population of 11.5 million, and an estimated 2.1 million smoking population age 18 and over, smoking-attributable direct medical costs were $1.3 billion. This worked out to $115 per person, or $619 per smoker. Another $1.4 billion was attributed to indirect costs of lost in-

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IDPA boosts obstetric fees for patients in pilot sectors

THE ILLINOIS DEPARTMENT of Public Aid (IDPA) has implemented a pilot program to ease obstetric care access problems faced by Medicaid patients in designated high infant mortality areas. The program responds to widespread dissatisfaction with public aid obstetric reimbursement rates. Many of those on the front lines have criticized its limited scope.

The IDPA restructured reimbursement plan, which came into effect October 1, targets 26 counties across the state, North Chicago in Lake County and 32 zip codes within Cook County for dramatically enhanced obstetric care fees.

The program is designed to improve access to prenatal obstetrical care for Medicaid patients, and, it is hoped, reduce infant mortality. According to Mark Camille, chief of the IDPA Bureau of Medical Practitioner Services, "Our recipients have difficulty in accessing OB care, and over the past several years the situation has been deteriorating. The decreasing number of OBs in practice and an increasing unwillingness to treat public aid recipients because of our low fees," he said, had exacerbated the situation.

How the pilot works

The Illinois Department of Public Aid provides increased reimbursement for prenatal care and delivery for patients residing in designated pilot program sectors. An unlimited number of prenatal visits will be reimbursed at $28, which is more than double the routine office visit level, on the assumption that additional time will be devoted to nutritional guidance and other counseling. Vaginal delivery will be reimbursed at $550, and both low cervical and classic cesarean section at $700. Post-partum care billing is unaffected.

For example, 10 prenatal office visits reimbursed at $280, a vaginal delivery at $550, and the six-weeks' post-partum visit at $41.90 would bring total reimbursement from the standard $446 to $871.90. The Department requires that each procedure be billed separately, using specific state-generated procedure codes rather than the all-encompassing CPT IV global code.

Scope of problem begs statewide solution

A $3.6 million legislative appropriation last fall enabled the Department to launch the pilot project in target areas. "We have attempted to do a significant rate increase," Camille said, "but we did not have enough money to do it on a statewide basis initially."

But the obstetric care access problem is not unique to the target sectors, and it is rooted in a host of environmental factors which strike common themes across the state.

For example, many observers point out that obstetricians who formerly provided obstetric care for the indigent can no longer cover professional liability premium costs. According to Carmi family practitioner Philip Boren, M.D., those costs have driven many southern Illinois OBs from the state. There are eleven southern Illinois counties with no obstetrical service, he says, and they account for about 2,000 deliveries annually.

"Those babies have to be delivered somewhere," he said, "so they go to Indiana, or Missouri, or Kentucky, and occasionally the baby doesn't wait and is delivered en route."

The Southern Illinois Medical Association (SIMA) has established a task force to assess and come to grips with the downstate obstetric care shortage which, according to Executive Director Dale Rosenberg, M.D., is "slowly deteriorating and threatening to get worse."

Physicians in upstate Lake County also formed a task force to help the local county health department deal with the 700-1000 public aid and medically indigent deliveries annually. According to Harry Burstein, M.D., a local obstetrician who served on the task force, physicians and hospitals there had overcome a frustrating series of bureaucratic obstacles, and come up with a solution which addressed all but the ubiquitous professional liability issue. "We had a plan," he said. "Everyone agreed. It was accepted. And it had to be scrapped (on advice of counsel) because of the medical-legal liability climate."

IDPA program expansion favored

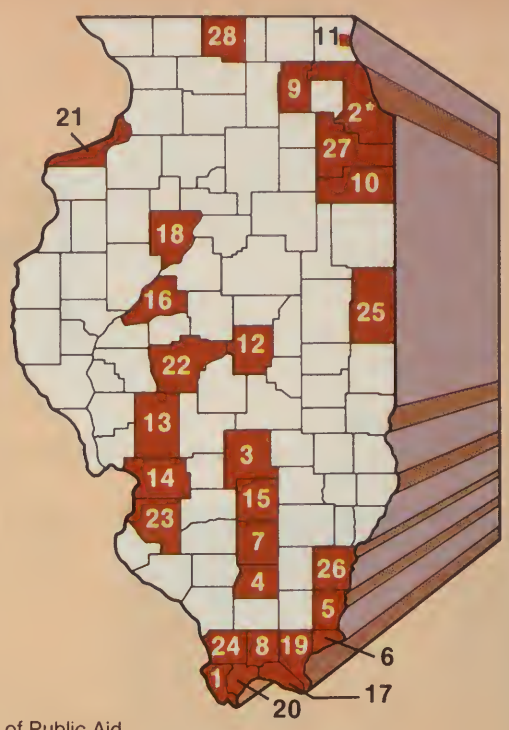
Arthur R. Traugott, M.D., chairman of the ISMS Committee on Third Party Payment Processes, said that the public aid department's pilot program is a good first step which needs to be expanded statewide. "We can acknowledge that obstetric care access is a very serious problem in the designated pilot sectors," Dr. Traugott said. "But it is no less serious in many other areas across the state."

According to IDPA's Camille, the department hopes to extend the pilot program to the rest of Illinois. "The intent is to expand the enhanced rates statewide as soon as it is fiscally possible," Camille said. "This will depend on our appropriations (from the legislature) for fiscal year 1990, which begins July 1, 1989."

Unless and until that happens, Medicaid reimbursement for patients outside the pilot program areas will remain at the traditional "global flat rate" for prenatal visits, delivery and post-partum care. ▲

Counties Targeted in IDPA Obstetrical Care Program

1. Alexander
2. Cook*
3. Fayette
4. Franklin
5. Gallatin
6. Hardin
7. Jefferson
8. Johnson
9. Kane
10. Kankakee
11. Lake (North Chicago only)
12. Macon
13. Macoupin
14. Madison
15. Marion
16. Mason
17. Massac
18. Peoria
19. Pope
20. Pulaski
21. Rock Island
22. Sangamon
23. St. Clair
24. Union
25. Vermilion
26. White
27. Will
28. Winnebago



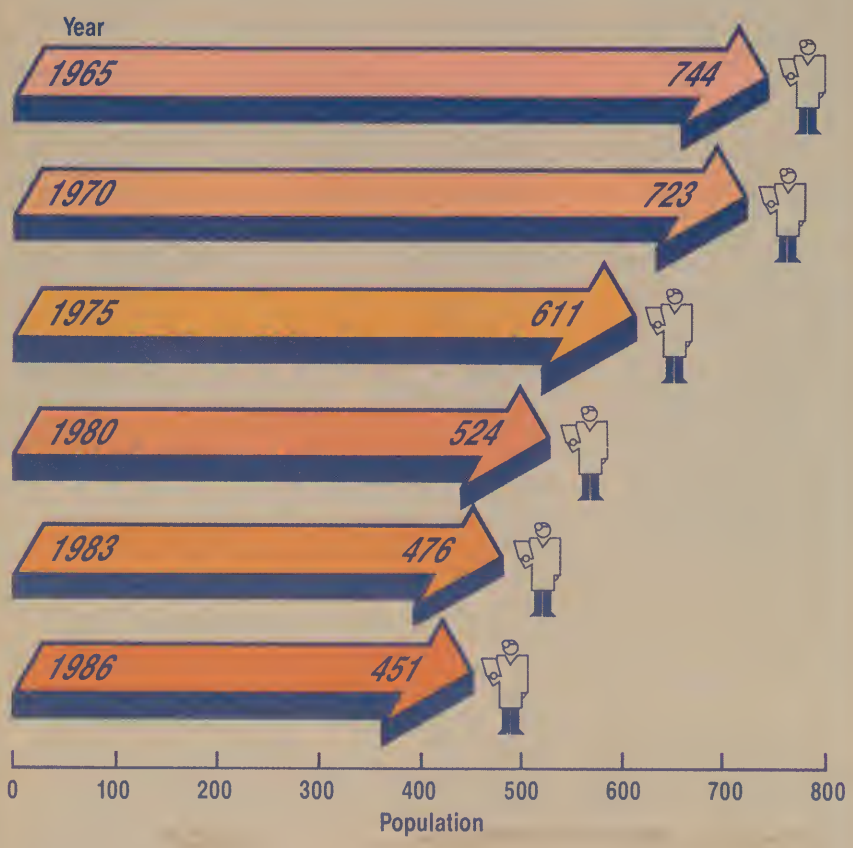
*The department has identified 32 areas in Cook County by the following zip codes:

60104	60153	60411	60426
60472	60606	60607	60608
60609	60610	60612	60615
60616	60619	60620	60621
60622	60623	60624	60627
60628	60629	60635	60636
60637	60639	60643	60644
60647	60649	60651	60653

Source of Data: Illinois Department of Public Aid

Physician Facts

Illinois' Population/Physician Ratio*



*Excludes persons and physicians employed by the federal government.

Source of Data: American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1987 edition.

Governor

(continued from page 1)

state could expand treatment of IV drug abusers and drug-related criminal offenders, and expand services for young persons and women.

He also called for enactment of a law to set penalties for the possession and distribution of anabolic steroids except when "legally prescribed for the treatment of disease."

Turning to medical indigency, the Governor noted that, even if fully funded, CHIP is a viable alternative for no more than 20,000 of the 1.5 million people in the state who currently have no insurance. He promised to "bring together the best minds and the boldest spirits in business, labor, health care, insurance and the General Assembly to develop a program of opportunity in health care."

The governor envisions a program that would continue the principle of employer-sponsored insurance as the primary source of health care financing, but would not contribute to escalating health care costs. He called for common sense solutions to health care delivery systems in Cook County and southern Illinois alike, and asserted that any new health insurance program requiring state funds "must have its own new and dedicated source of revenue to ensure its own stability."

The governor also proposed initiatives to improve the state's business and scientific competitiveness. ▲

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Families InTouch enlists physicians in battle against drug and alcohol abuse

by Laura Bianchi

FAMILIES InTouch, a newly created program to fight drug and alcohol abuse in Illinois, is enlisting physicians statewide in its campaign to educate parents and equip them with the tools they need to help their children develop healthy attitudes toward alcohol and other drugs.

"We see medical doctors as being on the front line of our educational campaign," said Alvera Stern, director of Families InTouch for the Illinois Department of Alcohol and Substance Abuse (DASA). "Medical doctors probably see more mothers, fathers and young children than any other professional in our society."

Stern believes that physicians have an important role as primary health educators for young families. If physicians are committed to this educational effort, she said, "we have made significant inroads into the health of American families."

Families InTouch is based on the premise that parents are the single most important influence over a child's risk of developing alcohol and other drug abuse problems. It targets the source of the problem—the home—as opposed to previous efforts which place the burden of "just saying no" on the young abuser.

Medical doctors probably see more mothers, fathers and young children than any other professional in our society.

"In our society, parents have largely underestimated their own influence on their children," said Stern, also advisor on parenting to the U.S. Department of Health and Human Services. "Parents mistakenly assume that peer pressure and other factors play a larger role than they do. The fact is, parents are the preferred source for information, and they remain so through mid-adolescence."

Briefly, here's how the Families InTouch strategy works:

- Public education through radio and television public service announcements, print media ads and interviews with DASA representatives.
- Distribution of Families InTouch booklets, brochures, press kits and posters through the State Board of Education. Among its publications, DASA has produced a book series for parents of children 5 to 16 that guides them in teaching their children about alcohol, other drugs and sex.
- Training for parents through two different classes: "Preparing for the Drug-Free Years" and "Talking With Your Kids About Alcohol." Roughly 70 people have been trained throughout the state to provide these classes.
- Training and materials for professionals in mental health, health care, alcohol and drug prevention and for members of the clergy.

Physicians not only can inform their patients about these InTouch services, but they are in a unique position to influence young families directly, Stern said, making them a significant component of the Families InTouch strategy.

"Physicians need to take the role of educator very seriously in terms of family history and family usage and in their role as assessor of future problems and preventative measures," Stern said.

Here are several areas, according to Stern, where physicians can make an impact:

- Investigating family history of abuse.
  Family history of abuse is a major predictor of a child's future abuse, Stern said, so physicians need to place as much weight on that aspect of a patient's medical history as they would on a history of diabetes or high blood pressure. Parents with a drug or alcohol problem, or whose extended families have a history of abuse, need to be warned of the increased risk to their children and encouraged to discuss that risk with their children.
- Educating preadolescent and adolescent patients.
  Stern cited evidence that more than half of all teens engage in sexual relations before age 15, and added that alcohol experimentation also begins earlier for modern youth.

"Kids are starting to drink between 11 and 15 now," Stern said, and pediatricians should take advantage of the annual physical to talk to teens about alcohol, drugs, sex and AIDS. Physicians have a "very, very crucial" preventive medicine role as educators for young patients, she said.

(continued on page 8)

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

CODING REMINDER FOR 1989

**CPT/HCPCS CODING — The 1989 CPT/HCPCS coding update will be *effective March 1, 1989.* You will be notified of the 1989 HCPCS coding changes in a special Medicare mailing. Please obtain your updated 1989 CPT coding manual from the American Medical Association at the following address:

American Medical Association
Order Department
Box 10946
Chicago, IL 60610

REMINDER — INTRAOCULAR LENS IMPLANTATION (IOL)

Medicare's "allowed amount" for an intraocular lens implanted during surgery may not exceed the *actual acquisition cost* plus a handling fee not to exceed 5% of the acquisition cost. Include an invoice with each claim you submit for an IOL. If the invoice is not received with the claim, payment for the IOL will be *denied*.

NEW MAXIMUM FOR OUTPATIENT PSYCHIATRIC SERVICES

As of January 1, 1989, the yearly maximum for outpatient psychiatric services was increased from $900 (1988's maximum) to $2200. This provides for a new yearly maximum payment of $1100. The formula applied to the $2200 maximum is the same as that applied to the previous $900 maximum:

$2200 x .625 (62-1/2%) = $1375 = "Reasonable Charge"
$1375 x . 80 (80%) = $1100 = Maximum Payment

HEALTH MANPOWER SHORTAGE AREAS (HMSAs)

Illinois HMSAs have not yet been determined by Health Care Financing Adm. You will be notified promptly once this information is received. It is likely the HMSAs will be portions/parts of a county, (a township, for example) rather than an entire county. Physicians serving in shortage areas designated as HMSAs will be paid a 5% bonus on a quarterly basis, whether or not assignment is accepted.

REMINDER — CHANGE OF ADDRESS OR SPECIALTY

It is very important that you keep us advised of your current address and specialty. We must maintain up-to-date records for services being rendered to Medicare patients. Please help us accomplish this by sending notification of changes in writing, to the following address:

Medicare Part B
Blue Cross and Blue Shield of Illinois
Provider File Unit
P.O. Box 994
Marion, IL 62959

(This report is a service to the physicians of Illinois)
2/17/89

Editorials

Governor's commitment is a healthy sign

It is encouraging to note that Governor Thompson's recent "State of the State" message signaled his intention to "bring together the best minds and the boldest spirits in business, labor, health care, insurance and the General Assembly to develop a program of opportunity in health care." An abundance of expertise, talent and wisdom is vital to finding an effective solution to the important problem of providing health care for the medically indigent, and we are glad that the Governor recognized the need for constructive planning.

Other states are also in the throes of battling the difficult problem of indigent care, and many proposals have been thrown into the hopper. Now, Illinois' leadership must confront the problem and develop an effective response.

ISMS intends to be an active, informed participant and willing resource as the state legislature debates the issue in coming months. The Governor has shown that he recognizes its importance. His commitment to pursue a resolution is good news for the 1.5 million uninsured citizens of Illinois and those who care for them.

Steroid abuse shows need for guidance

Steroid abuse, and its effect on young people, is much in the news. The Governor's call for legislative relief is only one of many signs that persons outside the profession are coming to see that inappropriate steroid use is genuinely dangerous.

The Illinois State Medical Society supports efforts to assure that steroids are dispensed only for appropriate medical purposes. Athletes, parents and team coaches must understand the consequences of steroid abuse. This is not a new campaign for ISMS. Formal policy in opposition to steroid use solely for improvement of athletic performance dates from 1985.

Steroids have an appropriate role in medical treatment. Yet government studies show that more than 60 percent of persons who admit to taking steroids say that they obtain them from the "black market." It is apparent that steroid abuse is a problem of inappropriate distribution and insufficient public understanding.

The "Board Briefs" column in this issue reports that five physicians have been chosen to receive the Society's Team Physician Award this year. Those five doctors are doing something concrete about the clear need for adult friendship and guidance in student sports. Each is a fine model for both amateur athletes and professional colleagues.

Illinois Medicine

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Harry A. Springer, M.D., *President*
Herold L. Jensen, M.D., *Chairman of the Board*

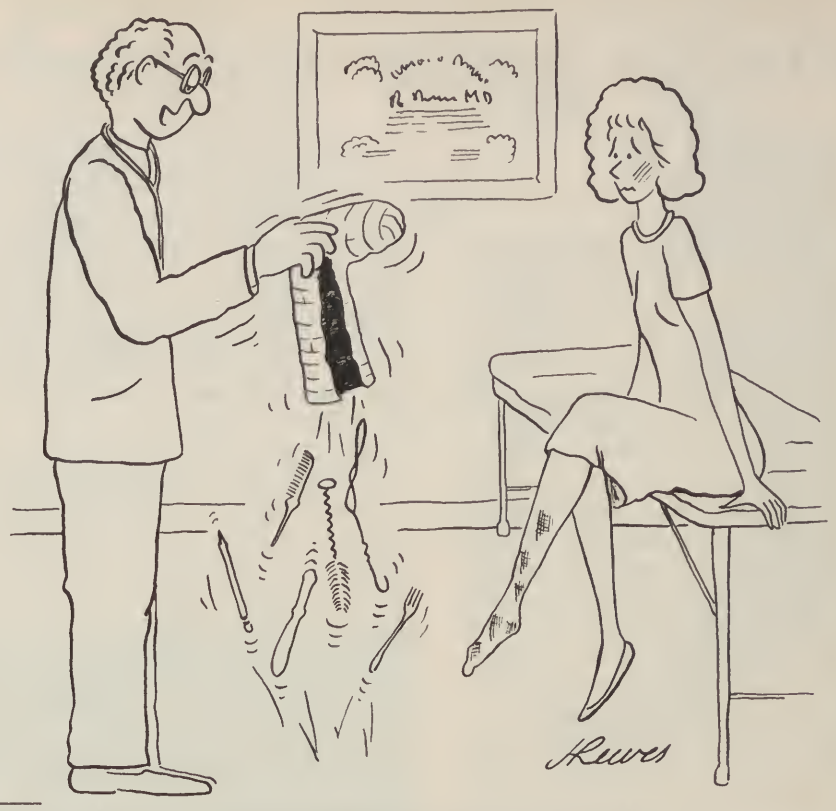
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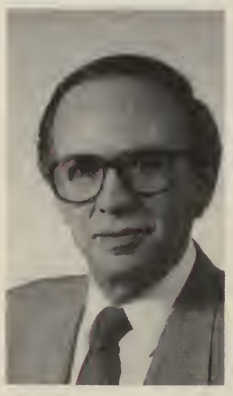
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"Tell me, Miss Jones, did you experience any itching problems?"

President's Column

For a healthier America



Harry A. Springer, M.D.

Society seems to be getting the message about the hazards of smoking. An Illinois Clean Indoor Air Act, narrowly defeated in the last legislative session, is again on the lawmakers' agenda.

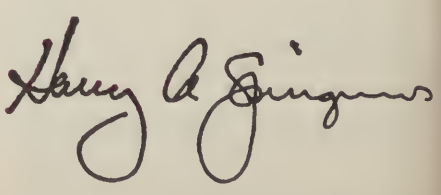
The political climate is gradually coming closer to accepting the medical community's contention that cigarette smoking is a public health hazard. Responsible civic and professional leaders have steadily brought the issue forward and kept it up front. Physicians, individually and as members of organized medical societies, have played a major role in getting the message to the public and to legislators ever since the Surgeon General's first report on the dangers of smoking was published in 1964.

There is no doubt that public attitudes are becoming more responsive to education about smoking as a dangerous drug, and more people are trying to quit. This is a major victory, and it is occurring despite the unceasing efforts of the $35 billion-a-year tobacco industry to avoid liability, to lobby legislators and to deny the clear link between cigarettes and so many unnecessary health problems.

ISMS members maintained their leadership role in the continuing fight against smoking last year. The ISMS House of Delegates called for an end to federal subsidies for tobacco farms. Instead, we recommended that the government spend an equal amount of money in the three years following an end of subsidies to help tobacco farmers convert their farms to other, safer crops. We recognize that tobacco farming is very profitable, but heroin production is also profitable, and is not supported by the government.

Last year, a clean indoor air ordinance was successfully passed in Chicago, an achievement made possible in part through support from ISMS members. Also in 1988, ISMS reaffirmed its long-standing support of the proposed Illinois Clean Indoor Air Act, which would ban smoking in all public places. Because that legislation failed to pass, Illinois remains one of only eight states without such a law.

We cannot afford to be discouraged. Although social progress always seems inordinately slow to those who seek it, attitudes are changing, and positive momentum is shifting toward those who seek a healthier America. As physicians and concerned citizens, we must maintain and accelerate efforts to bring the importance of this issue home to our patients and our legislators. ▲



Harry A. Springer, M.D.
President
Illinois State Medical Society

Board Briefs

The Illinois State Medical Society (ISMS) Board of Trustees met on Saturday, January 21, in the Society's Chicago offices. Full minutes are available to any member upon request; these synopses provide brief highlights.

ISMS Past President **P. John Seward, M.D.,** Rockford, appeared before the Board to share his perspective as chairman of the American Medical Association (AMA) Council on Legislation. Dr. Seward said that he was greatly concerned about anticipated cuts in the Medicare program and the ultimate form they might take. "The big concern," he said, "is the budget. And dollars—not programs—are what will drive policy decisions."

The debate over resource-based relative value scales, Dr. Seward said, presaged ominous trends in governmental control over physician practices. "It will get down to the point," he said, "where someone will be speaking to who lives, who dies and who decides."

Five team physicians who give volunteer time in high school or college athletics will receive the ISMS Team Physician Award in a ceremony at the state high school basketball championships in Champaign next month. **Irwin Smith, M.D.,** Northbrook, **Lloyd Blakeman, M.D.,** Orland Park; **Merle Denker, M.D.,** St. Charles; **Audley F. Connor, Jr., M.D.,** Chicago and **Theodore Grevas, M.D.,** Rock Island, were selected by the Board for that honor.

The Council on Public Relations and Membership Services successfully nominated **Paula Youngberg Arnell, M.D.,** Rock Island and **Patrick R. Staunton, M.D.,** Oak Park, for the 1989 ISMS Physician Public Service Award. In addition, the Board agreed to name **Edmund M. Jucewicz,** East St. Louis and **Monsignor Ignatius McDermott,** Chicago, as 1989 Nonphysician Public Service Award winners. The public service award presentations will take place at the Society's annual meeting in April.

Public Relations Council Chair **Jane Jackman, M.D.,** Springfield, also reported on an AIDS education brochure published in Spanish for Hispanic patients. The brochure is available upon request from the Society's offices.

The Board approved a unanimous recommendation by the ISMS-HMSS Governing Council for **Joseph L. Murphy, M.D.,** of St. Joseph's Hospital in Chicago, to seek a post on the AMA-HMSS governing council. Dr. Murphy is currently chairman of the ISMS-HMSS.

The ISMS Sports Medicine Committee will present an educational seminar on immediate care for football players' traumatic neck injuries at the March 30 annual meeting of the Illinois Chapter, American College of Emergency Physicians . . . The ISMS Council on Mental Health and Addiction reported that the Governor's Commission to Revise the Mental Health Code has released final recommendations. Council Chairman **Thomas Minogue, M.D.,** Champaign, told the Board that attendant legislative proposals would likely surface during this session of the Illinois General Assembly. Proposed amendments to the Code, he said, would probably fall in the realm of forensic issues, commitment and admission, the right to refuse treatment, informed consent and resources.

The ISMS House of Delegates will be asked to approve a Board of Trustees resolution dealing with hospital physician assistance committees. If approved, the Society will ask that the Joint Commission on Accreditation of Health Care Organizations and the Illinois legislature require that every hospital establish a medical staff mechanism to deal with the well-being of its members.

Council on Education and Manpower Chairman **Boyd McCracken, Sr., M.D.,** successfully recommended a second residency program directors' seminar to supplement the initial program in December, 1988. The first program covered documentation required for license applications, Medical Practice Act amendments relating to pre-1985 graduates and disciplinary policies regarding residents and residency programs. ▲

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New Exchange policy on post-cesarean delivery supports ACOG guidelines

PHYSICIANS SEEKING to facilitate vaginal obstetric deliveries for women who have undergone a previous cesarean section will be protected by a new policy of the Illinois State Medical Inter-Insurance Exchange (ISMIE).

The Illinois State Medical Insurance Services (ISMIS) Board of Directors, attorney-in-fact for the Exchange, approved coverage criteria for ISMIE policyholders who follow recent guidelines on vaginal birth after cesarean (VBAC) issued by the American College of Obstetricians and Gynecologists.

The policy allows ISMIE Class 2 family physicians to perform VBACs contingent upon prenatal consultation with a physician whose hospital privileges include C-section and appropriate back-up by such a physician during the delivery. "Back-up" is defined to mean that the physician qualified to perform C-sections is within 20 minutes of the hospital. A Class 2 physician will not be covered for performance of VBACs if these conditions are not met, and upgrading coverage to Class 3 will not suffice.

ACOG policy explained

The American College of Obstetricians and Gynecologists (ACOG) approved and published new suggested guidelines in October of 1988 that discouraged routine repeat cesarean births. ACOG's policy states that women with one previous cesarean delivery with a low transverse incision should be counseled and encouraged to attempt labor in a subsequent pregnancy, in the absence of a contraindication. ACOG policy further states that the trial of labor must be assessed on an individual basis. The guidelines call for professional and institutional obstetric emergency resources available within 30 minutes; a physician capable of evaluating labor and performing a cesarean delivery should be readily available.

In changing its policy, ACOG cited evidence from western Europe where VBACs have commonly been performed after cesarean sections with low transverse incisions. Further, a 1980 National Institute of Child Health and Human Development Conference on Childbirth concluded that vaginal delivery after cesarean birth is an appropriate option.

ACOG also stated that there is insufficient data to assess the safety or danger of labor for women with a previous classical uterine incision, as well as the effects of labor on a patient with more than one fetus, a breech presentation or excessive fetal weight (8.8 pounds).

The American College of Obstetricians and Gynecologists (ACOG) approved and published new suggested guidelines in October of 1988 that discouraged routine repeat cesarean births. Repeat C-sections had been thought to be less risky for both mother and child.

The increase in C-sections in recent years is often blamed on physicians' fears of liability. Repeat C-sections had been thought to be less risky for both mother and child. Recent evidence refutes that blanket assumption, and payors have sought to reduce the number of C-sections because of cost.

FP vaginal deliveries covered

"There is a shortage of obstetricians and gynecologists in parts of Illinois," said Robert C. Hamilton, M.D., chairman of the ISMIS Board of Directors. "Family physicians delivering babies can be rated Class 2 or Class 3, under limited circumstances, rather than the more costly Class 6 designated for OBGYNs. The Services board did choose a prudent route by requiring the consult and presence of a physician qualified to perform C-sections."

"The Exchange made this adjustment as a part of an ongoing commitment to ensure that insurance coverage is consistent with clinical standards," Dr. Hamilton said. "By happy accident, it might help in some small way to address the OB shortage in some parts of Illinois." ▲

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(ENALAPRIL MALEATE | MSD)

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been usetul in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy tor continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See OOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and AOVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without ditticulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases ot neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring ot white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart tailure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal tailure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the tirst few weeks of therapy.

Some patients with hypertension or heart tailure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE ANO ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development ot hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, it at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the tirst dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the tirst few days of therapy. It actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult wilh the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of intection (e.g., sore throat, fever) which may be a sign ot neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure ot all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure atter initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation ot treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized tor at least an additional hour. (See WARNINGS and OOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because ot demonstrated hypokalemia, they should be used with caution and with trequent monitoring ot serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation ot both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated tor safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 298/ patients.

Hypertension: The most trequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: tatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order ot decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and intarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Oepression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dystunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory intection.

Skin: Herpes zoster, pruritus, alopecia, tlushing, photosensitivity.

Other: Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include tever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be tatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypolension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% ot patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation ot therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation ot therapy in 1.9% ot patients with heart failure. (See WARNINGS.)

Clinical Laboratory Tesl Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% ot patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% ot patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart tailure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases ot neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations ot liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) It the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose ot 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Oosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose ot enalapril is recommended tor patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose ot VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized tor at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance ot hypotension after the initial dose ot VASOTEC does not preclude subsequent caretul dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range tor the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects*.) Oosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart tailure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions*.) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, it at the time ot dosage adjustment there is not excessive hypotension or significant deterioration ot renal function. The maximum daily dose is 40 mg.

For more delailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division ol Merck & Co., Inc., West Point, PA 19486. J6VS18R(815)

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Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Case #1

Presenting condition—A 26-year-old woman, pregnant with her first child, who had received her prenatal care from a family physician, went into labor at term and was advised by her physician to enter the hospital.

The case in brief—Upon admission, the woman was examined by her physician, who determined that she was in the first stage of labor. There had been spontaneous bag rupture at home. Labor seemed to be progressing normally. Fetal heart tones were good. A fetal monitor was attached for a brief time. However, the patient was extremely restless and so the physician discontinued monitoring. He then left the hospital, giving instructions to the nursing unit to call him when delivery seemed imminent or if there was any change in fetal signs.

One hour later the physician checked with the hospital and was told that fetal signs were still good and that the mother was continuing to dilate. Thirty minutes later, however, a nurse called to say that the fetal heart tone was deccelerating. Assuming this to be a normal physiological reaction to contractions, the physician did not come to the hospital for another 45 minutes. Upon his arrival, further fetal heart tone deterioration was noted and he immediately attempted an outlet forceps delivery, but with no success. He then called a consulting obstetrician/gynecologist who lived some distance from the hospital. The obstetrician arrived 45 minutes later, and a cesarean section was performed at once. However, the infant was stillborn with the umbilical cord wrapped around its neck. Efforts to resuscitate were unsuccessful.

The resulting claim—The parents sued the family physician, alleging that failure to monitor the fetus, failure to refer to a consultant in a timely fashion and delay in treatment resulted in the infant's death.

The outcome of the claim—A settlement was negotiated on behalf of the family physician for $125,000.

Why problems arose with this case—The family physician placed a fetal monitor but then removed it. When a nurse called to say that fetal heart tones were weakening, he did not act quickly to discern the seriousness of the problem, to call on a consultant or to precipitate delivery to prevent injury to the fetus. Because a consultant was not available to perform the cesarean section quickly, further delay occurred and the child was stillborn.

The points this case makes—A physician may face liability for failure to recognize changes in the status of a fetus during labor. If he or she fails to respond quickly when problems arise during labor, lawsuits may result.

- The American College of Obstetricians and Gynecologists (ACOG) has published guidelines governing various methods for determining and monitoring the condition of the fetus. A physician who fails to adhere to these guidelines is at risk of violating the local standard of care.
- Quick response to a call indicating that a problem is developing with a patient is imperative. Increasing numbers of lawsuits allege and substantiate delay in such responses by physicians.
- Under ACOG guidelines, when a family physician delivers infants, unless he is qualified to perform a cesarean section and holds hospital privileges that so specify, a qualified specialist to consult with and perform a section must be available within 20 to 30 minutes. When such assistance is not available within minutes, the physician risks practicing beyond his specialty, which increases liability exposure.

A physician may face liability for failure to recognize changes in the status of a fetus during labor. If he or she fails to respond quickly when problems arise during labor, lawsuits may result.



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(continued from page 3)

- Observing family management systems—discipline, communication and rules.
  Overly harsh parents as well as overly lax parents can contribute to future problems with abuse in their children, Stern said. A physician who suspects child abuse or lack of discipline "could address that" with the patient, Stern said.

- Healing thyself.
  One of the physician's major responsibilities is to his own family, Stern said.
  "So many of us in this work look at the client or patient as the major issue, but physicians are in a very high-risk category themselves because they are under stress," Stern said. "They need to examine their own alcohol and drug use and abuse and that of their families."



They do as you do

Physicians who are willing to join the front lines of this family-centered, educational approach to fighting drug and alcohol abuse can make a significant contribution to their patients and to the aims of the InTouch program.

"We want to give parents the courage to know they can make a difference," Stern said, "the tools with which to do that and the strength to know they can do it within the context of their own family values."

Editor's Note: For Families InTouch materials, classes and training programs, and for the name and number of each county's InTouch representative, please call 1-800-252-8951.

An ISMS brochure, "Substance Abuse—A Physician's Resource Guide" describes how to recognize and treat a substance abuse problem, and lists additional resources available through the ISMS Substance Abuse Education Program. Both the brochure and the program are funded through a DASA grant. Information about available materials can be obtained from the ISMS Division of Educational and Medical Services, Twenty North Michigan Avenue, Chicago, IL 60602, (312) 782-1654. ▲

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Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine.
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly). [061088L]

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A reluctant economist

by Toba Cohen

Prof. Uwe Reinhardt spoke at the November 1988 ISMS All Member Conference on economic dilemmas facing American medicine. He expanded on those comments in this* Illinois Medicine *interview.

UWE E. REINHARDT, PH.D., sometimes appears a reluctant economist. His position as James Madison Professor of Political Economy at Princeton University aside, he has not found a pure position of intransigent economic theory that is so often the hallmark of a "true" economist.

His problem seems to stem from a willingness to try any reasonable avenue to fulfill a personal and professional goal: he wants to find a way to assure that, as a nation, we will take care of "the sick kid of a poor gas station attendant with the same type of care the corporate executive's child gets." His gas station attendant family represents the 37 million uninsured Americans who, he says, are now left to, "fish around for a kindly doctor and hospital to take care of them. Then the hospital fishes around for someone to cover the cost. The doctor is expected to absorb it."

Reinhardt calls this a pin-the-tail-on-the-donkey kind of financing. And he calls it our national disgrace. He wants the American people to be reminded of the great tradition they once represented. "Americans," he says, "were once a very generous people." Now he sees the nation as mean-spirited. "They are not in the mood for redistribution. They associate health care with redistributing from the well and wealthy to the sick and poor."

In order to eliminate the disgrace of the 37 million, Reinhardt believes it will take some courageous political leaders to say that nationhood brings responsibility; in the case of health care, a short-run need to spend $20 or $30 billion more to take care of the poor.

Then we can move to the next step, cost containment. "For the last ten years and more, we have been trying to wrestle an awesomely-powerful cost-containment bear—the growing capacity of the health care system—to the ground. The bear is still out there," he says, "and by and large insured Americans make health care decisions absent price. They have very expensive taste."

Reinhardt describes the result as a health care sector wrestling match squeezing out the uninsured. He sees two ways to the financing solution: openly raising taxes or mandating employers to provide. In his mind it is a role for government and, thus, the taxpaying public.

There is a role for providers also. "Doctors and hospitals are not tax collectors," he says, "but we are really treating them as tax collectors when we expect them to find ways to finance health care for the poor." He explains that in Canada physicians do not have to worry about money when they treat a patient. At the end of the year a physician might be asked why he used so many x-rays, but he'd never be asked why he x-rayed Mrs. Jones. "And nobody would dare send Mrs. Jones a note saying we are not going to pay your doctor for this thing he did, because it was unnecessary, and he owes you a refund. That is outrageous."



Uwe E. Reinhardt, Ph.D.

Reinhardt believes that physicians must rally around a professional association and allow it to speak for them. "If they don't, all sorts of unilateral deals will be shoved down their throats, and that's not good for sick people."

"In some respects many of us are looking for some deal with physicians where you negotiate not only income, you negotiate regulations, you negotiate work conditions and so on to have a better accommodation with society," Reinhardt says. "Then, when a doctor is out there working, he or she doesn't feel bitter." He suggests that it is better for physicians to settle for a little less, to bring the variants in income across specialties a little closer together, than to be insulted.

"Rancor is not a good foundation for the healing arts," he says. And it certainly doesn't help bring health care to the 37 million ▲



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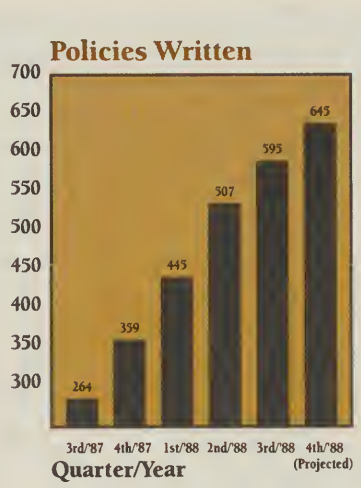
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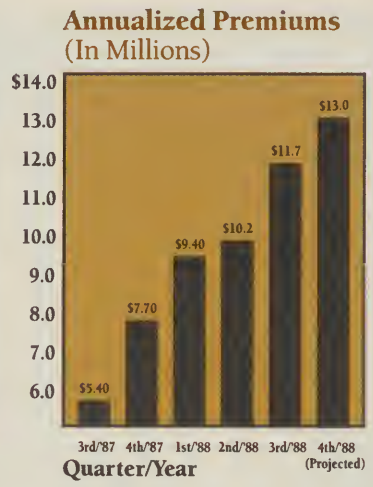
To Our Policyholders...

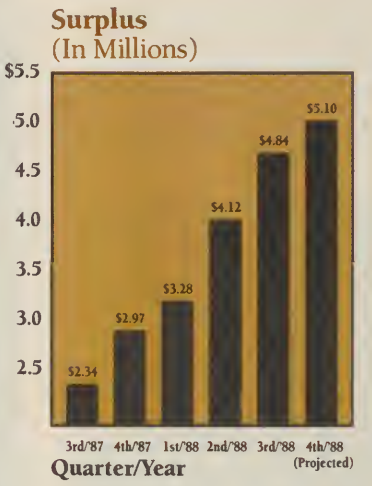
As we begin our third policy year of operation, I would like to say "thank you" to the policyholder/owners of Associated Physicians Insurance Company. Your intrepid support of APIC in its infancy is what made possible our emergence as the "other" physician-owned malpractice insurance company in Illinois.

The dedicated leadership of your physician colleagues on the Board of Directors has guided the remarkable growth of APIC through 1987 and 1988. With your input and support, APIC's board has crafted an operating philosophy that promises APIC will remain fiscally sound and competitively priced in 1989 and beyond.

As the accompanying charts clearly illustrate, APIC's growth in policyholders and in premiums written has been accompanied by similar growth in the company's surplus – the real measure of APIC's financial foundation. In addition, APIC's assets now exceed $12 million.







Today, we protect more than 600 physicians in every corner of Illinois and in virtually every clinical specialty. Each of you should be congratulated for believing in yourself and in your ability to create a viable professional liability insurance alternative. On a personal level, my involvement with APIC has provided the most satisfying experience of my 30+ years in the insurance business, and I thank you for the opportunity to be a part of APIC's success.

To Those Illinois Physicians Who Have Not Yet Joined Us...

We understand the caution that you have exercised by remaining with your current malpractice carrier. After all, your ability to practice medicine relies to some extent upon your insurance protection. That is exactly why the managers and directors of Associated Physicians have so diligently endeavored to deliver a professional liability alternative that addresses your most serious insurance questions.

We are proud of the fact that we are Illinois-licensed, and that we provide a unique blend of physician ownership, management by insurance professionals, and local service through independent agents located near you. We take pride in the reinsurance protection that insulates us from catastrophic losses. And we also are proud of the performance of our investment advisors, The Chicago Corporation, and of our auditors, Coopers & Lybrand.

Most of all, we are proud of our ability to provide you with premiums that are extremely competitive, while delivering important policy features such as "consent to settle" and free "tail coverage" for five-year policyholders who have attained age 55 and are retiring from practice. This exceptional combination of price and coverage creates an insurance value that is second to none.

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Henry Nussbaum

Henry Nussbaum
President
Associated Physicians Insurance Company

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ASSOCIATED PHYSICIANS INSURANCE COMPANY

Clean Air Act

(continued from page 1)

come due to premature death or disability. This breaks down to $126 per person or $680 per smoker.

According to IDPH, the Illinois cigarette tax generated $175 million in 1985. When the cigarette tax revenue is subtracted from the estimated direct and indirect smoking health care costs, there remains an annual deficit in excess of $2.5 billion.

The other side

Opponents say that the bill will do little to eliminate indoor air pollution, and is an infringement on the right of businesses to determine their own smoking policies.

Harry L. (Bud) Kelley, executive director of the Illinois Association of Tobacco and Candy Distributors, said in a telephone interview, "If a building is properly ventilated, there is absolutely no problem with smoking." He said the answer is to let the business owner decide the best way to deal with smoking in the workplace.

"Our concern with the Act, and with legislation like it, is that it represents government intrusion into the workplace and into the employer/employee relationship," said Don Hughes of the Illinois State Chamber of Commerce.

Hughes said that many businesses belonging to the State Chamber are taking steps to address the smoking problem without a government mandate, either through improved air circulation and designated smoking areas, or other types of arrangements. "There just isn't a need (for the legislation)," he said.

"A lot of companies do, but a lot don't (designate smoking areas)," said Luke Burchard, M.D., of Mattoon. "We cannot rely on every individual employer to make accommodations for their employees."

Dr. Burchard and other physicians regard smoking in public places as a public health issue, not one of unwarranted government intrusion in the private sector.

"There is massive evidence that shows that passive smoke causes lung cancer and other lung problems, heart problems, and that children in families who smoke have 25 percent more pulmonary problems than children growing up in smoke-free homes," said Charles Westfall, M.D., spokesman for the Illinois Chapter of the American Cancer Society.

Passive or "side-stream" smoke is the smoke that is inhaled by nonsmokers located in the vicinity of a smoker. Dr. Westfall said that for years the American Cancer Society refrained from supporting smoking legislation because there were other ways to get people to stop. However, when it was determined that passive smoke posed a real health hazard, the Society decided to push for legislation "to protect the health of the nation."

Dr. Turnock said that the concentration of toxic and carcinogenic substances in "side-stream" smoke is 70 percent more concentrated than that found in "mainstream" smoke, which is the smoke directly inhaled by the smoker.

Kelley objected to the bill's narrow focus. "It's not a 'clean indoor air act,' it's a 'no smoking' bill," he said. Kelley said that the bill makes no provision for ensuring proper ventilation or the elimination of other pollutants existing in ventilation ducts that get pushed into the air, especially in older buildings. He said that cigarette smoke is only one of several pollutants contained in indoor air and that legislation should attack the entire problem.

"If they want to solve the problem, let's work on a real clean indoor air bill," he said. He also contended that indoor smoking amounts to four percent of indoor air pollution.

Dr. Westfall flatly disagreed, countering that cigarette smoke is "the greater part of the contamination." He and Dr. Burchard cite studies by both the U.S. Environmental Protection Agency and several universities substantiating the claim.

Although Kelley did not refute Dr. Turnock's statistics, he challenged the Department to substantiate them. "My other question for Dr. Turnock is 'Will passing this bill do away with all those medical expenses?' "

Kelley predicted that IDPH would be unable to answer that question affirmatively if asked in a committee hearing. He also said that the state will have to recover "$325 million in lost revenue in just the (state) cigarette tax alone," not counting county and local cigarette taxes.

While several opponents said they think similar legislation will eventually pass, they do not think it will happen this session. "I don't see any pressure building for passage," the State Chamber's Hughes said.

Terzich said that although the tobacco lobby is a formidable opponent, he hopes to muster enough votes in the committee he chairs to send the bill to the floor.

"Increased public awareness should help," he said. "It is hard for me to appreciate legislators voting against it."

ISMS President Harry A. Springer, M.D., reaffirmed the Society's unqualified support for the bill and called on members to lobby their legislators on its behalf.

"It is important for physicians to take a stand against smoking because of the clear health risks it poses to smokers and those around them," Dr. Springer said. "Secondary smoke is harmful—we do not believe nonsmokers should be forced to jeopardize their lungs and hearts by inhaling smoke of those who choose to take that risk." ▲

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5900 radiologic techs must show CME by March

MORE THAN half of 11,000 accredited radiology, radiation therapy and nuclear medicine technicians employed by Illinois physicians and hospitals will lose their accreditation if they fail to meet education requirements prior to March renewals, according to the Illinois Department of Nuclear Safety.

An Illinois law, passed in 1982, requires that "persons who apply ionizing radiation to human beings" meet minimum standards for accreditation. One of these standards is an average of 12 hours' continuing medical education each year. Now, all technicians accredited in 1984 must show completion of an average 60 hours' continuing medical education at the March 1989 five-year renewal. The law applies to technicians working in all settings, including physician offices.

According to a Department spokesman, all technicians applying for renewal, and their employers, should examine credentials carefully, since civil penalties can be brought by the state against anyone performing radiologic technology procedures without valid accreditation. Applicants for renewal will have 90 days following application to complete CME requirements before accreditation is withdrawn.

Questions may be directed to the radiologic technology accreditation program at the Illinois Department of Nuclear Safety (217-785-9913). ▲

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

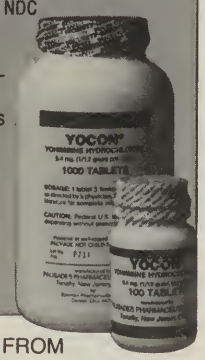
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Residency program staff seminar
A 1:00 p.m. seminar in the DPR Chicago offices on February 16 will describe the licensure process, new rules and new application forms. The program could benefit both residency program directors and those assistants who are responsible for completing applications. Further information is available through the Department's Pat Eubanks: (217) 782-7827.

State Disciplinary Actions*

*The physician and surgeon license of **Deja Suthikant,** 1521 S. Ninth, Charleston, was suspended for six (6) months and placed on indefinite probation after he prescribed controlled substances in lethal combinations and in the presence of drug addiction and drug-seeking behavior. His controlled substances license was revoked.

*The physician and surgeon license of **Joselito C. Reyes,** 2901 S. King Dr., Chicago, was issued on five (5) months' probation after he performed acts which could constitute the unlicensed practice of medicine.

*The physician and surgeon license of **Afifa Mina,** 720 Elm St., Itasca, was reprimanded after she made misrepresentations on her application in a sister state resulting in a discipline.

The physician and surgeon license of **Bryson Ahlers,** South 19th and Union, Tacoma, WA, was indefinitely suspended after he was disciplined by the State of Washington for the incompetent or negligent practice of medicine.

The physician and surgeon license of **Stanley Miller, M.D.,** 342 Old Town Rd., E. Setauket NY, was indefinitely suspended after his medical license was disciplined by the State of New York.

The physician and surgeon and controlled substances licenses of **Paul N. Van Gorder, M.D.,** 708 W. Oakdale, Chicago, were restored after he successfully petitioned the Department to remove the licenses from probationary status after he complied with the terms of probation.

*The physician and surgeon and controlled substances licenses of **Anton Zubak, M.D.,** 5948 W. Roosevelt Rd., Chicago, were revoked after he prescribed controlled substances for nontherapeutic purposes.

The physician and surgeon license of **Patricia Von Behren,** 800 E. Carpenter, Springfield, was restored without restriction after she successfully petitioned the Department for restoration.

*The physician and surgeon license of **Clyde Henry, M.D.,** 8641 Saginaw, Chicago, was reprimanded and fined one thousand five hundred dollars ($1,500) after he practiced medicine without benefit of a renewed license from August 1, 1987, through February 9, 1988.

The physician and surgeon license of **Gonzalo Robles, Jr., M.D.,** 5732 W. North Avenue, Chicago, was restored on indefinite probation after he successfully petitioned the Department for restoration. While on probation he may only practice medicine in the course of his employment with Professional Health Care Specialists, Chicago, and his practice shall be limited to screening patients, physical examinations, and blood chemistry work.

The physician and surgeon license of **Priyakant S. Doshi, M.D.,** 300 E. 33rd Street, New York, NY, was placed on eighteen (18) months' probation after he was disciplined by the State of New York Department of Health.

The physician and surgeon license of **David Ling, M.D.,** was placed on one (1) year's probation after he was disciplined by the State of California Board of Medical Quality Assurance.

**Indicates ISMS member*

**This periodic update on actions taken against physicians disciplined under the Medical Practice Act is reprinted by permission from the Illinois Department of Professional Regulation Monthly Disciplinary Report. The Department is solely responsible for its content.*

News Capsules

MEDICARE DIAGNOSIS CODES REQUIRED

Effective April 1, 1989, federal law will require that all Medicare Part B claims be submitted with International Classification of Diseases Ninth Edition Clinical Modification Diagnosis Codes (ICD-9 CM). The American Medical Association (AMA) has persuaded the Health Care Financing Administration to postpone penalties for noncompliance until at least June 1, after which failure to comply can result in a fine of up to $2,000 per incident or exclusion from the Medicare program.

The ISMS Committee on Third Party Payment Processes will continue to monitor this initiative to ensure that issues such as use of nonspecific diagnosis codes and potential application to nonassigned claims are raised.

ICD-9 CM is published in three volumes, and is available from several sources, including the U.S. Government Printing Office. Requests there should be directed to: Superintendent of Documents, U.S. Government Printing Office, Washington D.C. 20402 (202) 783-3238.

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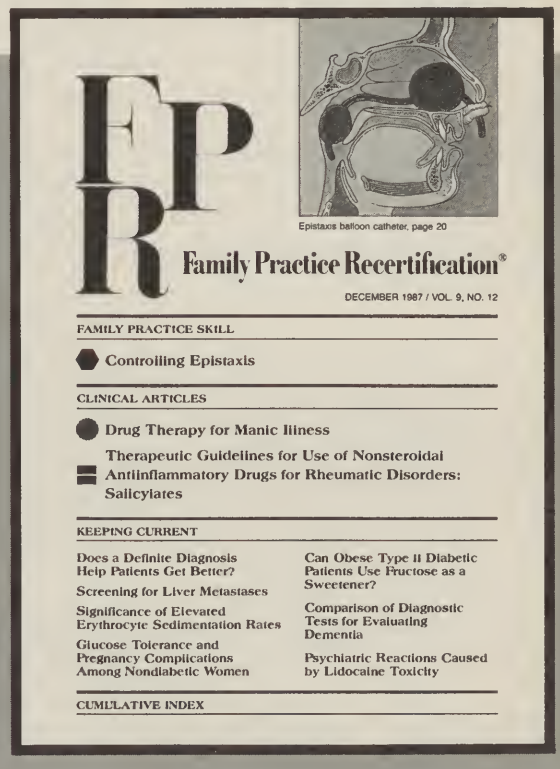
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Family practitioners—internist needed for southern Illinois family-oriented community. Hospital sponsors physician with salary guarantee, office space, etc. Income potential for physician geared toward small community lifestyle. For additional information, write Administrator, Fairfield Memorial Hospital, N. W. 11th, Fairfield, IL 62837, or call collect (618) 842-2611.

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Twenty-nine physician multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D. F. Sweet, M.D., Fond du Lac Clinic, S.C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

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Internist, pediatrician and family practitioner needed for northern Illinois community health center. Multi-specialty group seeks additional practitioners for busy clinic and hospital practice. Academic affiliation, excellent salary and benefit package in pleasant, affordable city. Contact John F. Frana, Executive Director, Crusader Clinic, 1204 West State Street, Rockford, IL 61102. (815) 968-0286.

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Triplicate RX Progress Report . . .

Illinois Medicine

March 3, 1989

ILLINOIS STATE MEDICAL SOCIETY



U.S. to study Ill. hospital closings

SENATOR PAUL SIMON (D-Illinois) has successfully persuaded the U.S. General Accounting Office (GAO) to assess factors causing Illinois' rural hospitals to close their doors. The senator said that he had requested the study because Illinois had experienced 32 hospital closings in rural communities in the last eight years.

The GAO has targeted five rural communities: Avon, Cairo, Paxton, Whitehall and Beardstown. Physicians in neighboring areas may be contacted as resources for the study, which is intended to help government leaders understand the problems faced by rural communities coping with access problems.

GAO researchers will interview physicians, hospital administrators, community leaders and others to look at issues related to Medicare reimbursement, political problems, and access to health care without a local hospital. They will seek out ideas on how to prevent other rural hospitals from closing. "We need an overall look at these communities, and recommendations as to what can be done to save the hospitals," Simon said. "We should do more to encour-

(continued on page 9)

Rules to calibrate labs near

by Karen Sandrick

THE ILLINOIS Department of Public Health (IDPH) published draft regulations last week to implement amendments to the Illinois Clinical Laboratory Act passed in 1987 by the Illinois General Assembly.

Physicians will be required to comply with the new Illinois law as of July 1, 1989. Illinois will require that any physician office laboratory providing specified tests in the office for the physician's own patients register annually with the state. Those who perform tests for others on a referral basis will have to meet the same standards as a licensed independent clinical laboratory. A graduated series of regulatory requirements keyed to testing complexity apply to those who fall between those extremes.

State regulators do not yet know whether the Illinois rules will be deemed comparable—and therefore exempt from—federal rules due out July 1, 1991. They do know that the 1988 federal law gives national authorities broad powers to regulate physician office laboratories. And they hope that the Illinois initiative, which anticipated national pressures to regulate laboratories, will be permitted to supplant the upcoming federal regulations.

According to David Bogard, a member of the IDPH clinical laboratory technical staff, the legislation tailored a 20-year-old professional practice law, "to accommodate the rapidly changing medical scene that includes many different kinds of settings for clinical laboratory practices, whether they be HMOs, hospital laboratory extensions or doctors' offices."

(continued on page 5)

Registration Class Tests

Physicians whose office laboratory services are limited to the following tests for their own patients will be required only to register annually with the Illinois Department of Public Health.

- Urinalysis measured by the use of a chemically impregnated strip (dipstick) or tablet;
- Hematocrit by centrifugation;
- Occult blood;
- Urine pregnancy testing (semi-quantitative chorionic gonadotropin);
- Hemoglobin;
- Erythrocyte protoporphyrin using a hematofluorometer;
- RBC sickle cell screen using dithionite, sodium hydrosulfite;
- Wet mounts for yeast or trichomonas;
- Blood cholesterol testing;
- Blood glucose testing;
- Syphilis serology by macroscopic agglutination including RPR and VDRL;
- Gonorrhea limited to cultures for growth or no growth, oxidase and lactodose, gram stains testing; and
- Any tests personally conducted and interpreted by a physician for his or her own patients.

Source: Illinois Department of Public Health



Dan Rostenkowski

Proposed $5 billion Medicare cuts wholly unrealistic: Rostenkowski

ILLINOIS CONGRESSMAN and House Ways and Means Committee Chairman Dan Rostenkowski (D-Ill) has flatly rejected the possibility that Congress might be persuaded to approve a $5 billion cut in the Medicare budget as proposed by the president.

"The chairman just doesn't see any way that this congress will support a $5 billion cut in Medicare," a Rostenkowski spokesman said.

Earlier this month, President George Bush proposed that the fiscal year 1990 Medicare budget be increased by $8 billion, rather than the $13 billion automatically projected by the Medicare formula. Budget lines for reimbursement to physicians and hospitals would be

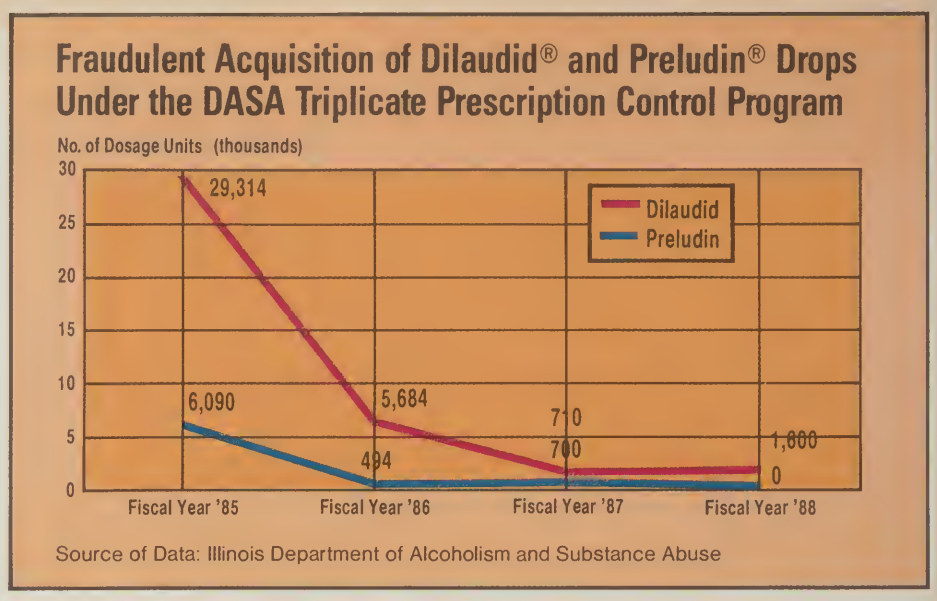
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Triplicate Prescription Program reduces fraud and abuse involving controlled substances



by Laura Bianchi

FOUR YEARS after taking charge of the Illinois Triplicate Prescription Control Program, the Department of Alcohol and Substance Abuse (DASA) is calling the program a "significant success" in reducing fraud and abuse in prescriptions for controlled substances. Under Illinois law, physicians prescribing designated controlled substances must write the prescriptions on state-provided triplicate forms.

In a recent four-year analysis of the triplicate program, DASA reports it sharply curtailed the number of illegally written or stolen prescriptions for Dilaudid® and Preludin® and it assisted in bringing sanctions against a number of key doctors, pharmacists and drug abusers and dealers in Illinois.

Mark T. Bishop, Deputy Director of DASA, reported the following statistics and information illustrating the department's efforts to deter prescription fraud and abuse:

- Between fiscal years '85 and '88 the number of illegally written or stolen triplicate prescriptions, which were then "cashed" at a pharmacy, plummeted from 380 to 12.

Because of that, the amount of illegally obtained Dilaudid units dropped from 29,000 to 1,500 during that same time period and the amount of illegally obtained Preludin units fell from 6,000 to none.

The reduction in those two drugs is particularly significant because they are the two most sought-after street drugs in Illinois according to law enforcement officials.

Part of the reason for that remarkable reduction is simply the department's decision to print each doctor's name and address on their triplicate prescription forms, Bishop said. A pharmacist now can see immediately if a prescription originated from another area and can then call the physician to verify it.

"The revamped forms are less of a target for thieves because it puts a geographic limitation on them," Bishop said.

Further, the form is easier for doctors to use, and it allows DASA to monitor Illinois prescriptions that show up in border states.

- Between fiscal years '85 and '88 DASA was directly involved in bringing licensing sanctions against 58 doctors, 24 pharmacists and 20 pharmacies. Of the 58 physicians, DASA was instrumental in revoking the controlled substance licenses of 43.

One particularly interesting case involved an Illinois physician who was responsible for 50 percent of physician-dispensed prescriptions for one particular amphetamine, Bishop said. The doctor operated a weight-loss clinic and had been prescribing amphetamines to some of his patients for over 20 years. Recently that physician's license was placed on probation.

"Any physician will applaud the removal of dishonest physicians from the profession," Bishop said.

- Beyond that, the Triplicate Program has helped identify nearly 200 different criminal "doctor shoppers" who are capable of "scoring" roughly 100 illegal prescriptions a month. In that same vein, the program has helped identify patterns of abuse state-wide that indicate a drug diversion gang is at work and what direction it is moving.

"We can punch up a number and examine patterns of misuse that wouldn't be apparent (by examining records) in a single doctor's office or pharmacy," Bishop said.

A drug diversion gang is capable of obtaining 100,000 units of Dilaudid during a sweep through the state. But because those gangs never visit the same doctor or pharmacy more than once, "It would be almost impossible to pick up that kind of activity without the triplicate program," Bishop said.

- Since DASA took over the triplicate program the number of doctors involved has grown from roughly 10- or 11,000 in 1985 to nearly 14,500 in 1988. That's 43 percent of the 33,409 physicians who hold Illinois controlled substance licenses.

DASA is continuing efforts to increase the number of participating physicians by appealing to professional medical organizations for support.

Briefly, this is how the program works: Any doctor with a medical license, controlled substance license and DEA license who wishes to prescribe designated products may apply to DASA for a packet of 100 prescription forms printed with his/her name and address. The prescriptions arrive with a list of drugs that are classified as controlled substances.

When the doctor writes a prescription for one of those drugs, one copy goes to the pharmacy, one goes to DASA and one stays in the doctor's office. Information from those forms is entered into DASA's computer system and is analyzed to determine patterns of prescription writing and filling.

In light of DASA's success thus far, Bishop said, the department will be broadening its campaign against the abuse of prescription drugs in several areas.

One of the new thrusts will be in the education and training of doctors who prescribe controlled substances. The department's Medical Advisory Board is expected to review a recommendation this year for training programs for doctors who deal with pain management therapy or who head up substance abuse programs, two particularly important areas involving controlled substances.

"I have noticed over the years that most students out of medical school get very little training in prescribing the controlled substance drugs," Bishop said. "If a doctor is not up to date on substance abuse he or she can be susceptible to scams."

If a doctor is not up to date on substance abuse he or she can be susceptible to scams.

The department also will begin to examine state-wide data later this year on the typical dosage, number of prescriptions and instructions for use of controlled substances which could be developed into general guidelines for pain management therapy, Bishop said.

Further, DASA also is investigating several other drugs—butyl nitrate, steroids and anorectics—to determine if they should be added to the Schedule II.

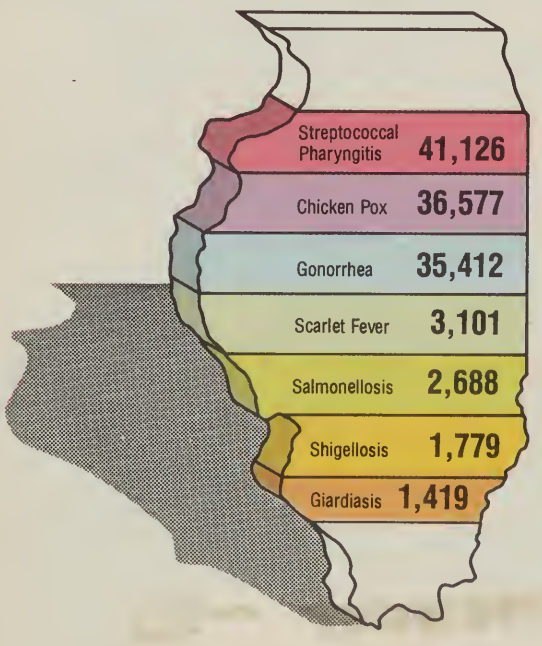
Since DASA assumed control of the triplicate program, ISMS has worked closely with the Department to help develop the triplicate form, the rules governing its use, and through a DASA grant, drug abuse education materials for use by ISMS members.

"Part of our success must be credited to the level of communication and cooperation that has existed among medical professionals, pharmacy professionals, medical societies, pharmacy associations and federal and state governmental agencies," Bishop said. "However, there is a continued need to identify and sanction unscrupulous professionals who prescribe and/or dispense dangerous drugs outside the law for personal gain.

"Information sharing," Bishop said, "has been our most effective tool in the control of diversion."

Physician Facts

Seven Reportable Diseases with Highest Incidence in Illinois in 1988



Source: Illinois Department of Public Health. These are provisional totals as of February, 1989.

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Faculty, staff show concern about proposed UI/Reese pact

by Kevin O'Brien

ISSUES OF academic integrity and quality care for medically indigent patients are fueling potentially stiff opposition to the University of Illinois' proposed affiliations with the Michael Reese Hospital and Medical Center and Cook County Hospital, as well as the county's proposed use of the university hospital.

On February 8, a vote of "no confidence" in the university's central administration came at the end of a meeting of members of the university hospital's medical staff. The meeting was called by the University of Illinois Hospital medical staff President John L. Skosey, M.D., to present a plan for addressing concerns raised by the proposed agreements.



John L. Skosey, M.D. President, University of Illinois Hospital medical staff

Approximately 350 members of the university's College of Medicine faculty, hospital medical staff, and faculty from other health colleges approved that resolution with one dissenting vote.

They also passed a resolution to:

- Oppose the "closing" of the University of Illinois Hospital;
- Endorse proposals to continue and expand support services at Cook County Hospital;
- Obtain an affiliation agreement with Michael Reese that would be "fair to the university;"
- Stipulate that the Michael Reese affiliation be one which "preserves the academic integrity of the College of Medicine."

University spokesman Mike Maggio called the "no confidence" vote "illegitimate," because it did not occur during a duly constituted meeting of the hospital medical staff or College of Medicine pursuant to medical staff bylaws or university statutes.

"It was not the College of Medicine voting," Maggio said. "It was an expression of concern in the progress towards the development of this plan by some employees, faculty, support staff and others."

Dr. Skosey said that, as medical staff president, he had the authority to call a meeting to which he also invited concerned faculty members and employees of other health sciences colleges and the hospital. He also said that the meeting was attended predominantly by College of Medicine faculty.

On February 22, Dr. Skosey and Rush Medical College professor Stuart Levin, M.D., jointly called another meeting to discuss an alternate proposal to affiliate their two institutions with Cook County Hospital and West Side Veterans Administration Hospital. Approximately 350 attendees approved a recommendation that the leadership of each institution discuss it.

University president Stanley O. Ikenberry issued a statement characterizing the Skosey/Levin proposal as "loose talk" designed to "produce confusion in the talks now ongoing" with Michael Reese and the county. He said that he and Rush-Presbyterian-St. Luke's Medical Center President Leo Henikoff, M.D., had discussed a potential merger several months ago, and decided not to pursue an affiliation.

West Side V.A. spokesmen declined comment and Cook County Hospital officials were unavailable. A spokeswoman for Rush confirmed Ikenberry's account, saying that an affiliation with the university was a "dead issue." She also said that Dr. Levin was acting as an individual and not as a representative of the medical center.

The next day more than 100 community activists, doctors and concerned citizens met to seek ways to mobilize professional, community and media support. Plans were made to contact legislators and stage demonstrations in Chicago, and in Urbana-Champaign when the University Board of Trustees meets on March 9.

Issue remains before UI trustees

The proposed affiliation came under public scrutiny when the University of Illinois Board of Trustees voted 8-1 in January to approve "in principle" a proposed agreement with Michael Reese, announced December 20, 1988. Under the agreement, Michael Reese would become the primary teaching facility for students of the university's health sciences colleges. The trustees also instructed the university administration to seek an affiliation agreement with Cook County Hospital. In addition to the affiliation agreement, Cook County would obtain use of the 517-bed University of Illinois Hospital.

University officials have said that the Michael Reese agreement could be ready for the March board meeting, but that they do not yet know whether it will be presented for consideration by the board at that time.

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REPORT FOR *Illinois Physicians*

BLUE CROSS AND BLUE SHIELD OF ILLINOIS CARD GUIDE HOSPITAL PREFERRED PROVIDER PROGRAM

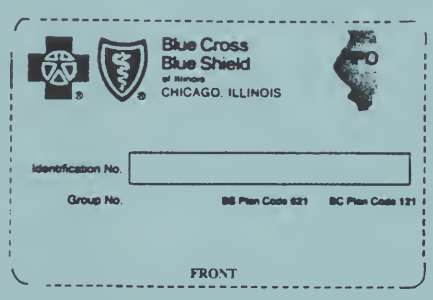
The Hospital Preferred Provider Program (PPO) is a health care benefit program designed to provide Blue Cross and Blue Shield of Illinois (BSBSI) subscribers with economical incentives for using designated hospital providers.

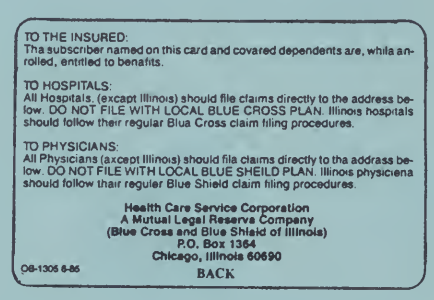
A Directory of Participating Hospitals is given to BCBSI subscribers with the PPO Benefit Program. The selection of participating hospitals is based upon the range of services, geographic location and cost effectiveness of care. The subscriber will be notified by BCBSI of any changes to the participating hospitals listed in the directory.

Blue Cross and Blue Shield of Illinois encourages physicians to assist those subscribers with the Hospital PPO benefits to obtain the greater benefit levels by utilizing a PPO hospital for their health care services. The "Blue Cross and Blue Shield Report for Illinois Physicians" issue dated 12/87 listed the PPO hospitals effective January, 1988, which are still in effect January 1, 1989.

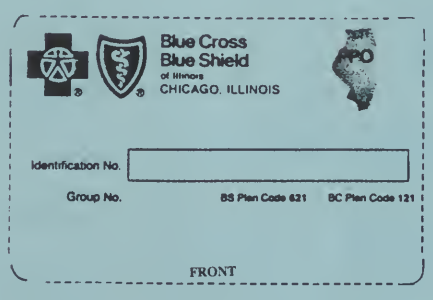
Below are examples of the BCBSI insurance cards issued to subscribers with the PPO Program benefit. Our standard Hospital Preferred Program (PPO) includes the Medical Services Advisory (MSA) Program. The phone number on the back of the card will put the subscriber or physician in contact with the Medical Services Advisor. MSA was featured in the February 3, 1989 issue.

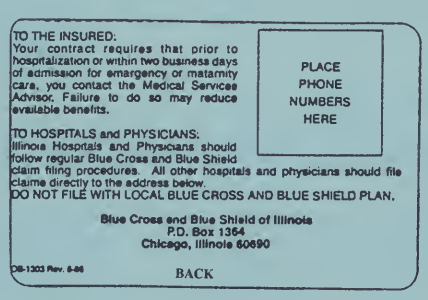
PREFERRED PROVIDER PROGRAM (PPO)





PREFERRED PROVIDER PROGRAM (PPO)/MEDICAL SERVICES ADVISORY (MSA)





Most BCBSI subscribers with the Hospital PPO Benefit Program can also be identified by the "P" prefix in the group number. Some other groups with the Hospital PPO Benefit Program are *FEP, Chicago School District, and American Stores*.

Currently Illinois Bell Telephone Company and Ameritech Services, Inc. have the BCBSI PPO Physician Benefit Program. The PPO Plus Product is currently being marketed to certain employer groups. These PPO Physician Benefit Programs will be featured in the April and May, 1989 "Blue Cross and Blue Shield Report for Illinois Physicians".

(This report is a service to the physicians of Illinois)
3/3/89

Editorials

Medicare cuts: dangerous surgery

The president's proposed budget puts potential Medicare cuts on the surgical schedule again this year. The specifics are not yet available, but the budget negotiation process will be underway until October. As physicians, we must be ready for active combat in the battle since, once again, federal officials seem to view Medicare funding reductions as a convenient way to solve the deficit dilemma.

For the past several years, Medicare has repeatedly suffered from congressional refusal to fund the program fully, despite federal mandate. Health care professionals have watched with alarm as budget reductions which ultimately threaten quality of care were achieved.

Now it's time to protect the Medicare program—and our patients—from further attack. This approach needs and deserves strong support from responsible, enlightened legislators. ISMS members can be cogent, persuasive advisors to our congressional representatives. Physicians can point out the damage to patient care quality and to the entire health care system which would result from further Medicare reductions. We encourage every physician to be ready to communicate with congressional representatives on Medicare funding.

An opportunity to offer aid

Fighting drug abuse isn't easy. But the success of Illinois' triplicate prescription program is a good example of how physicians working cooperatively with pharmacy professionals, law enforcement and regulatory agencies can make a difference. Under its aegis, the illegal diversion of many dangerous drugs has been substantially reduced.

This program, however, bucks a tidal wave of substance abuse, driven by the seemingly insatiable demand for illegal drugs. Customers are getting younger and younger, with drug peddling in our high schools and even grammar schools making daily headlines throughout Illinois. A recent *Journal of the American Medical Association* report attests to the scope of the problem. The number one killer of youth is accidental death, according to *JAMA*. In fact, teens are the only age group whose health status has not improved over the last thirty years, it says.

As physicians, we must look out for the total health and well being of our patients. That means knowing how to spot trouble signs of substance abuse. Taking the time to do a patient history which flags potential abuser behavior. And "talking straight" to young patients—both in the confidential confines of the examination room and in local schools and community organizations—about the dangers of taking risks with drugs and alcohol.

Kids need to hear the medical facts—plain and simple—from an authoritative source other than their parents. That's the message ISMS President Harry Springer, M.D. is delivering to media, physicians and community organizations as he travels the state this year.

Illinois doctors are in a unique position to offer aid. Let's not let this opportunity pass us by.

Illinois Medicine

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Letters for publication should be no longer than 300 words. All letters must be signed, and should be addressed to: Editor, Illinois Medicine, *Twenty North Michigan Ave., Suite 700, Chicago, IL 60602. The editors reserve the right to edit letters submitted for publication.*

AIDS Premarital Screening Test

I disagree with your editorial position on premarital AIDS testing. The average charge for the ELISA HIV test more accurately determines the cost of premarital AIDS screening in Illinois. The Illinois Department of Public Health uses its own charges of $35 for an HIV test to make an estimation of the costs Illinois newlyweds spent in 1988. However, they never surveyed physicians to find out what the average charge to patients was. Most physicians can obtain the test for a cost of $10. Any charge to patients above $25 for the screen appears inappropriately excessive.

Using these lower figures we find that all charges are decreased by almost 30%. The total amount spent now becomes $4 million and the cost per each of the 23 identified cases of AIDS decreases to $170,000. A recent study[1] determined that average lifetime costs for HIV infected children approach $100,000. As earlier intervention and more effective HIV therapy become available this cost will unquestionably increase. One child in the report had incurred medical costs in excess of $500,000.

Most children born infected with AIDS will die before 6 years old and generate expenses over $100,000. This country now has 10,000 such children and that number is expected to double in two years. The AIDS virus has already infected one in 300 college students. The cost effectiveness of premarital AIDS testing will certainly improve as the AIDS epidemic inevitably increases its spread into our population.

Preventing the conception of an AIDS infected infant will more than compensate for the expense and inconvenience of premarital AIDS screening. Confirming that your lifelong partner and potential children are free of the most devastating infection this planet has ever known is a worthy goal. A couple spending $50 premaritally to accomplish this would be one of the more prudent investments that they could make.

Joseph M. Mercola, D.O.
Chairman, AIDS Committee
Humana Hospital, Hoffman Estates

1. Hegarty, J.D., Abrams, E.H., Hutchinson, V.E., *et al.*: "The Medical Care Costs of Human Immunodeficiency Virus—Infected Children in Harlem," *JAMA* 1988:260:1901-1905.

IDPH Replies:

According to Illinois Department of Public Health spokesman Tom Schafer, the $35 estimate for the cost of an AIDS test is based on the experience of its own counselling and testing centers. The direct cost of the test itself is $13. The remaining $22 covers the salaries and time of IDPH counsellors who explain test results and counsel patients, as required by Illinois law.

"The direct cost of the test is an irrelevant issue," says Schafer. "The counselling and analysis of the test is most important—and the major cost associated with premarital testing." ▲

Medical Licensure Rules

After reading the (article about) new medical licensing rules for the State of Illinois which (stated that the rules) require two years of core clinical rotations in surgery, medicine, pediatrics, psychiatry and obstetrics/gynecology, we were astonished to discover that under these rules almost no graduates of American medical schools can qualify for licensure in Illinois. Almost all medical schools in the United States require only 12-15 months of traditional core clinical rotations in surgery, obstetrics/gynecology, pediatrics, psychiatry and internal medicine. The remainder of the two clinical years is taken up by electives in radiology, pathology, emergency medicine, research, medical history, epidemiology, medical ethics, to mention only a few. In addition, many of the core rotations are taken at other medical schools not formally affiliated with the student's school in order to enhance the student's likelihood of acceptance into particular postgraduate residency programs. The top students at most schools, with the approval of their dean, often will spend 6-8 months of their senior year at other schools. If the proposed new Illinois medical licensure rules become implemented as stated, a major crisis in providing hospital based health care in Illinois will develop on July 1, 1989 as the result of new interns and many residents being unable to obtain licensure to begin functioning on that date.

Finally, the notion that a "blue ribbon panel of physicians and state officials," most of whom have no experience or qualifications for medical education decisions, would have the presumption to mandate medical school curricula for the whole country, apparently without consulting any medical school dean or the American Association of Medical Colleges, is mind-boggling.

Linda Shelton, Ph.D., M.D.
Allan L. Lorincz, M.D., Chicago

The Department of Professional Regulation Replies:

As Drs. Shelton and Lorincz correctly point out, the new Medical Practice Act requires two academic years of study in the clinical sciences, but not solely in the core clerkship rotations. Within this two year period, students must take core clerkships in internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery—each running for at least four but no more than twelve weeks. For the remainder of the two year clinical study period, students are free to pursue electives. The core rotation can be completed at another teaching facility, as long as it is affiliated with a medical college officially recognized by the jurisdiction in which the medical school which conferred the degree is located. Please note that this affiliation requirement applies only to non-LCME approved schools. ▲

Clinical Lab Act

(continued from page 1)

Illinois is the sixteenth state to pass a law regulating physician office laboratories. Most, like Illinois, make special allowances for physician-performed testing. Many, unlike Illinois, require that those laboratories maintained by groups of physicians meet the same standards as independent clinical laboratories.

Illinois' regulatory effort comes at a time when physician office laboratories are undergoing increased scrutiny nationwide because of their phenomenal growth. Peter Soto, M.D., Belleville, member of the IDPH clinical laboratory advisory board, pointed out that "many doctors, depending on their specialty or interest, have always done some lab work in their offices for convenience. With the advent of highly automated instruments that are reasonably priced and easy to operate, there has been a rapid expansion of the number of tests done in the physician's office."

Nationally, physician office laboratories have been multiplying at a rate of about 16 percent a year. The Federal Health Care Financing Administration has estimated that in 1988, there were approximately 100,000 high-volume physician office laboratories and that the labs performed approximately 25 percent of all lab testing, accounting for about $5 billion a year.

Quality control

As physician office laboratories have expanded, so have concerns about their quality. A July 8, 1988 paper in the *Journal of the American Medical Association* reported that 44 percent of the workers in physician office laboratories have no formal laboratory education or training. Health and Human Services Inspector General Richard Kusserow has worried that only seven percent or less of physician office laboratories participate in voluntary proficiency testing or quality control programs. Preliminary results of a 1988 survey of 230 members of the Illinois Society of Internal Medicine showed that 59.9 percent of those who maintained office laboratories already had established quality control procedures, but only 24.6 percent voluntarily participated in proficiency testing.

The new Illinois regulations establish uniform quality control standards for all laboratories, including physician office laboratories which only perform testing for their own patients. In addition, the regulations outline six clinical laboratory classes. Any physician office laboratory which limits testing to the patients of that practice will fall into the Registered, Permit Class I, or Permit Class II designation.

The Registration Class applies to physicians in a "single practice" of medicine who perform certain designated (or "registered") tests. The designation requires only that the physician register the laboratory with IDPH each year. In this context, the "single practice" of medicine is defined as that of one or more licensed practitioners sharing facilities, per-

(continued on page 7)

CARAFATE®
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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987; 9(4):395-399.

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Policyholder Services Committee

Have a question about your Exchange malpractice insurance? Do you wonder how your premium is established or what kind of coverage you should consider? Do you have questions about the services provided, or suggestions about how the Exchange can better serve its policyholders? Answering yes to any of these questions means you should know about the Illinois State Medical Inter-Insurance Exchange Policyholder Services Committee and its network representatives.

"The Policyholder Services Committee was formed with the mission of establishing an information network that would be responsive to the needs of policyholders," said Boyd E. McCracken, M.D., Greenville, chairman.

To fulfill this important mission, the committee recruited volunteer physician policyholder representatives from hospital medical staffs. These network representatives, who serve on 97 percent of the state's hospital medical staffs, act as liaisons between the Exchange and individual policyholders. Their job is to provide information about professional liability and assist insureds with particular professional liability problems.

Network representatives meet with Exchange leaders twice a year to receive current information and share input that they have received from individual policyholders during the course of the year. The dialogue enables ISMIE to identify policyholder needs and respond with new services.

"This system has worked out very well," Dr. McCracken said. He stressed that network representatives are not insurance sales people.

While the information network has been the committee's major activity, it is by no means the committee's only communications avenue. The committee has developed a video library to teach physicians methods to reduce liability exposure. Tapes are loaned on a no-cost basis for 14 days. Most are accompanied by a manual which policyholders may keep for future consultation.

Tapes currently in the library are:

- "The Physician Defendant: Your Deposition" explains the function of a deposition and instructs physicians on how to prepare for it.
- "The Physician Defendant: Your Trial" picks up where "Your Deposition" leaves off. This tape offers advice on preparing for and testifying at a malpractice trial as a defendant. Dramatizations are used to illustrate effective testimony before a jury and how to avoid costly mistakes on the witness stand.
- "Managing Your Risk in the Office/at the Hospital" is a double-feature video demonstrating how communication breakdowns and mismanagement of patients' cases can increase a physician's liability exposure. A variety of topics are examined, including record keeping practices, informed consent, billing and collection procedures, managing the health care team, telephone communication techniques, scheduling, test tracking procedures, and referrals and consultation. Physicians are urged to share this tape with their staff.
- "Anatomy of a Malpractice Trial" examines a mock trial presented at the 1987 ISMS All Member Conference. Using videotaped scenes from the mock trial, two professional attorneys analyze defense and plaintiff strategies. The camera also goes into the jury room where we see and hear how the jury reached a decision. The tape offers lawsuit prevention lessons, as well as lessons on trial tactics and courtroom behavior.
- "Anatomy of an ISMIE Claim," dramatizes typical scenarios in the course of a medical malpractice claim. A loss-prevention emphasis brings home the types of events which can lead to unnecessary, readily prevented medical malpractice liability.

Any of these tapes or manuals may be ordered through the ISMIE Network at 1-800-782-ISMS.

The committee also has published a brochure, "Coping With The Stress of Malpractice Litigation," which educates physicians on the psychological and emotional dimensions of being a defendant in a malpractice suit, and how physicians can effectively cope with the experience.

Wide range of activities

The committee is responsible for policyholder communications. It provides ideas for *Illinois Medicine* features on current trends in the Illinois insurance marketplace, Exchange policy and claims experience.

The committee is always "brainstorming" to identify emerging policyholder needs and create services to meet those needs, Dr. McCracken says. For example, they plan an educational program to explain the impact of "tail" coverage and its potential for limiting physicians' relocation options. The committee is also considering a new brochure on this important topic.

"The committee has spent a lot of time lately discussing how we can better inform newly-insured physicians to be aware of things they can do to lower their risk of being sued for malpractice," Dr. McCracken said.

Consequently, a well received seminar to educate newly-insured policyholders about good practice behaviors, and how to minimize their liability exposure and enhance their ability to defend suits was held in conjunction with the 1988 ISMS All Member Conference in November. The committee recommends that all policyholders, especially those beginning their careers, seek opportunities for continuing risk management education. Also, as a direct result of work in risk management education, a new Risk Management Committee has been established to better concentrate on this important activity.

The committee also keeps abreast of what services other professional liability insurance companies are offering, as well as the liability climate in general, Dr. McCracken said. He views the committee's work as an "information loop"—providing information and receiving information.

Dr. McCracken wants every policyholder to know that there is probably a network representative on his or her hospital's medical staff, and that policyholders should not hesitate to contact the representative with questions, problems or suggestions for making the Exchange work more effectively. Policyholders who do not know the name of their network representative are urged to contact the Exchange.

"This is *our* insurance company," he concluded, "and the Network is a valuable tool in keeping the company responsive to its physician policyholders." ▲

Surgicenter coverage clarified

IN RESPONSE to inquiries from policyholders, the Illinois State Medical Inter-Insurance Exchange (ISMIE) has issued updated information regarding coverage for their practice activities at surgicenter facilities.

Physicians seeking coverage for surgicenter activities should submit a written request to the Exchange underwriting department. The department will advise whether or not the surgicenter is an acceptable location for ISMIE-insured physicians. If not, appropriate forms will be sent to the facility administrator.

Several factors enter into the assessment of physician coverage for surgicenter practice activities. Some examples are the following:

1. If surgical procedures constitute 50% or more of the facility's activity, or if abortions are performed on the premises, the facility must be licensed by the Illinois Department of Public Health.
2. Surgicenters must carry professional liability insurance with adequate limits of liability. Written verification of such coverage is required annually. Self-insured facilities must provide an annual written description of coverage.
3. A physician who performs surgical procedures in a surgical suite which is an extension of his or her office practice must complete surgicenter forms in order to ensure coverage.
4. Procedures performed at the center must be among those approved by the Exchange; unapproved procedures must be evaluated specifically.
5. All physicians and other licensed health care personnel must be adequately insured either through the center or individually. ▲

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—A 62-year-old woman experiencing gastric problems was referred to a radiology department by her internist for tests, including a barium enema.

Subsequent outcome—The woman died shortly after the contrast study.

The case in brief—During the procedure, the radiologist noticed that the barium enema tip had been erroneously inserted by the hospital technologist into the vagina and the balloon portion had been inflated. Although the tube was quickly extracted, the error caused laceration of the vagina. Barium spilled into her blood stream, causing pulmonary embolism and death.

The resulting claim—The woman's family sued both the radiologist and the hospital in which the procedure had been performed, alleging that the barium enema tip had been improperly placed, causing the pulmonary complications and her death.

The outcome of the claim—The radiologist was found to share in the liability, despite the fact that a hospital technologist had made the error. The total judgment awarded was $60,000, of which the radiologist was responsible for $18,000.

Why problems arose with this case—The physician's liability turned on the question of who was responsible for the supervision and control of the technologist who made the error. Under the "captain of the ship" doctrine, the supervising physician was apportioned a degree of comparative fault.

The point this case makes—A degree of supervisory responsibility accrues to the physician overseeing a given procedure. That supervisory responsibility should not be taken lightly and a physician should make every effort to assure the competence of those individuals upon whom he must rely or with whom he must work in performing his particular medical or surgical activities. ▲

(continued from page 5)

sonnel, income and expenses for a clinical laboratory used solely for their own patients.

A Class I permit applies to physicians in a single practice of medicine who perform, in addition to the tests itemized for the Registration Class, "simple" tests. IDPH, in consultation with their clinical laboratory advisory board, will determine which "simple" tests meet that definition. This permit class requires the physician to pay an initial $50 and annual $25 fee, to have an established quality control program and to participate in proficiency testing.

A Class II permit applies to complex testing by groups of physicians or HMOs that operate a laboratory for their own patients. There is no limitation to the types of testing that may be done at this level. This classification requires annual fees, inspection every 30 months, established quality control procedures, proficiency testing, and trained personnel (*i.e.*, a technician or a technologist) to perform testing.

The Class III permit and protocol categories concern only health screening laboratories that process cholesterol and glucose testing. Most physician office laboratories do not fall in these categories unless they are involved in health screening activities such as health fairs.

A final classification is a licensed laboratory which is fully regulated. Again, it is important to note that the physician office laboratories which accept referrals fall into this classification and are subject to the same regulations as an independent clinical laboratory.

What do the regulations mean for physicians who maintain a laboratory in their offices? For one thing, the regulations will raise the cost of operating an office laboratory for those laboratories which do not have established quality control guidelines or do not participate in proficiency testing programs. Costs may be considerable for physicians who maintain laboratories that fall in the Class II category. Not only will these physicians be required to pay annual fees ($100 initially and $50 each year thereafter), but they will need to hire trained laboratory personnel.

Richard Sassetti, M.D., Chicago, chairman of the Illinois State Medical Society laboratory services committee, explained that the new regulations will mean additional paperwork. "Physicians will have to apply for a permit and maintain records," Dr. Sassetti said, and some will be required to meet quality control, personnel and inspection procedures.

However, as IDPH's Rob Kane noted, physicians themselves can choose the degree to which their offices will be regulated. "A physician or group of physicians can apply to be licensed at practically any one of the permit levels. This is part of the freeing of the regulatory scheme so physicians can decide where they want to be regulated by the tests they do."

Public hearings on the clinical laboratory regulations will be held around the state during the week of March 13. IDPH can provide copies of the draft regulations, and advise on hearing dates and locations. ▲

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Fiberoptic Colonoscopy
June 21—23, 1989

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June 23—24, 1989

Fiberoptic Esophagogastric Endoscopy
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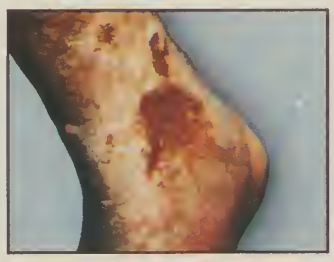
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Dr. Kremper was a practicing OB-GYN until April of 1988 when illness forced the then 45 year-old physician to retire from practice.

Although he had been an APIC policyholder for less than a year, Dr. Kremper was given "tail coverage" at no charge due to his disability. This provision in his APIC policy saved Dr. Kremper over $119,000, and allowed him to enter his retirement with the knowledge that he would have coverage for future claims that might arise from his former practice.

Furthermore, since he had purchased APIC's "prior acts" coverage in lieu of a tail policy from his previous commercial carrier, Dr. Kremper will be fully protected for all claims that might arise from treatment dating back to July 1 of 1982 – the date he purchased his first claims-made policy from the commercial carrier.

Dr. Kremper describes his situation:

"It was difficult for me to accept having to stop my practice of medicine. But with my APIC policy still in force, I at least knew I wouldn't have to worry about what might happen if I were to get sued after I retired. And it was a big relief knowing that I didn't have to come up with an extra $119,000 in premium."

Today Dr. Kremper serves on the Board of Directors of Associated Physicians Insurance Company. His involvement there helps to assure that responding to the needs of our physician policyholders will always be a top priority at APIC. And it comes from the unique perspective of a physician who's "been there".

Some people may wonder how an insurance company can afford to provide free tail coverage to totally disabled physicians, or to a physician's estate in the event of death.

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Rostenkowski

(continued from page 1)

trimmed to effect the savings.

"The chairman has made it very clear that the $5 billion in cuts recommended by the president is wholly unrealistic," the spokesman said, "and that a cut of that size would jeopardize both the availability and the quality of care," for Medicare patients.

Rostenkowski has been quoted as saying that while Ways and Means will study the Bush proposal, it would be "the bitterest debate and fight that we in the Ways and Means Committee ever experienced." He characterized past negotiations to trim $2 billion from the 1988 Medicare budget as "the most difficult period in the health arena that I've ever spent."

Rostenkowski is not greatly concerned by statements from senior administration officials suggesting that the president was prepared to risk a Gramm-Rudman sequester rather than compromise on budget legislation. "The president needs to take a close look at just what would be cut under Gramm-Rudman and what would not," the spokesman said. "Social Security is protected, and the Medicare total vulnerability is capped."

The spokesman said that while Rostenkowski would clearly prefer to avoid a stalemate, which might trigger mandatory across-the-board cuts under Gramm-Rudman, "he wants to send a message to the administration that they're better off with that than the budget proposal." Gramm-Rudman strictures protect Medicare outlays in excess of 2% from any across-the-board cuts, he said. ▲

He characterized past negotiations to trim $2 billion from the 1988 Medicare budget as "the most difficult period in the health arena that I've ever spent."

GAO study

(continued from page 1)

age hospitals in underprivileged areas."

"One problem is that, generally, hospitals in underprivileged communities serve people who need help the most," Simon said. Exaggerated community need is compounded when facilities close and neighbor institutions must pick up the slack.

"When people have to travel far for care, my guess is that there is an added cost to the federal government, as the remaining hospitals must provide more care and services," Simon said. "As a result of closings, the government loses money and people lose care." ▲

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Two Dates Lead to a "Perfect Match"

ILLINOIS MEDICAL students eagerly await Wednesday, March 22, 1989, the "Match Day" which determines where they pursue their residency training.

There is, however, another key date to remember. It falls 60 days before the residency program begins—or May 2 for July 1 residencies. By that date a completed application for temporary licensure (with all supporting documentation) must be filed with the Department of Professional Regulation (DPR). "The Department cannot guarantee that late or incomplete applications will be processed in time for incoming residents to receive licenses prior to the start of their residency training," according to DPR spokesperson Maureen Mulhall.

Medical residents without temporary licenses cannot treat patients—and if they do, are subject to discipline under the rules of Illinois' Medical Practice Act. Mulhall says that "in the neighborhood of 25 to 30 residents have been cited for this violation so far."

While hospital personnel often file temporary licensure applications for residents entering their institutions, incoming residents are ultimately held responsible for providing supporting documents and obtaining their own licenses. New residents should check with their program directors, and take steps to assure that temporary licensure applications are in the works well before the program begins, and that the license is in hand before they see patients. ▲

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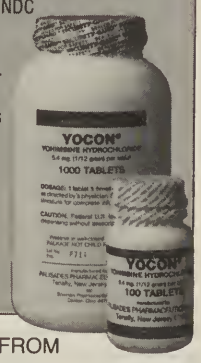
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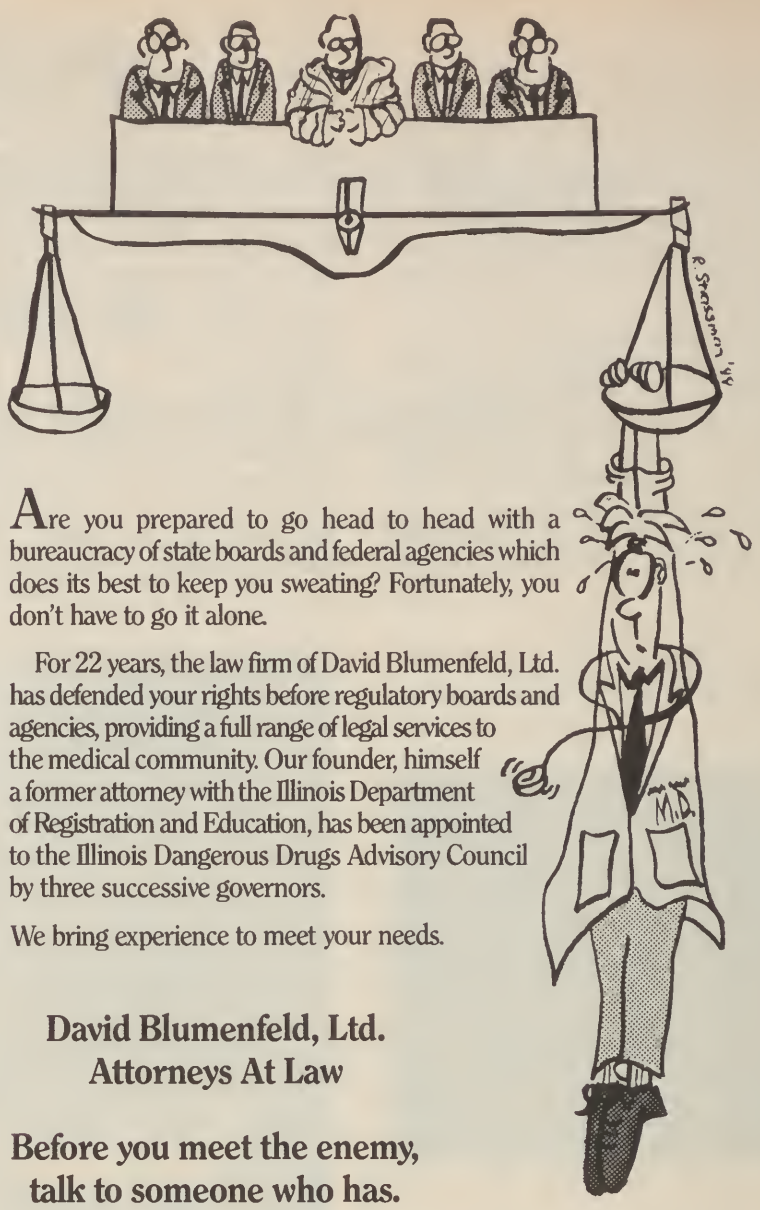
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3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Mandatory assignment back in the hopper

ILLINOIS LAWMAKERS will again debate the merits of mandatory Medicare assignment, say two senior citizen organizations and three state legislators who combined forces on March 2, to announce introduction of a bill limiting Illinois physicians' Medicare charges. The legislation would make it illegal for Illinois doctors to charge or collect from senior patients any amount in excess of Medicare's "reasonable charge," and would require doctors to post a notice to that effect in their offices and include it in their patient bills. Rural areas with "health manpower shortages" are exempted from the mandate.



Chief sponsors of the mandatory Medicare assignment bill are (L to R) Rep. Anthony Young (D-Chicago), Sen. William Marovitz (D-Chicago), and Rep. John McNamara (D-Oak Lawn).

The announcement, which came during a state capitol news conference, elicited a strong, immediate response from the Illinois State Medical Society. "Medicare patients are already guaranteed a physician's lowest rate for any service," said the ISMS statement. According to government statistics cited by ISMS, health care providers already accept the Medicare assigned rate as payment in full for 68 percent of Medicare claims paid in Illinois.

Chief sponsors of the mandatory assignment bill are Senator William Marovitz (D-Chicago), Representative John McNamara (D-Oak Lawn) and Assistant House Majority Leader Anthony Young (D-Chicago).

The two senior citizen organizations—The Illinois State Council of Senior Citizens and the Illinois chapter of the American Association of Retired Persons—vowed to lobby statewide for the bill. They charged that Illinois doctors "overcharged elderly and disabled patients $138

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Governor's budget targets enhanced health care access

FUNDING INCREASES aimed at improving access to health care services headlined Illinois Governor James Thompson's fiscal 1990 budget proposal, which was officially unveiled in a speech before the General Assembly March 1st. Thompson said that while the $21.8 billion budget plan "does not fund all of services needed by our citizens, . . . it does bring welcome improvements that will be seen and felt throughout our state."

Medicaid increase possible

Prominent on the list of improvements is $17.4 million more public aid dollars, partially targeted toward improving health care access for both downstate's and Chicago's poor. Chronic Medicaid underfunding has been blamed for a dearth of physicians willing to take on the often high-risk cases which indigent patients represent. Other health care

(continued on page 2)

U.S. Justice Dept. blocks Rockford hospital merger

by Janice Rosenberg

IN FEBRUARY, 1989, U.S. District Court judges reached decisions on two antitrust suits brought by the United States Justice Department against proposed hospital mergers. The cases, in Roanoke, Virginia, and Rockford, Illinois, both involved nonprofit institutions and together were the first suits brought by the Justice Department against nonprofit hospitals.

The outcome of these suits was of vital interest to the litigants as well as to the hospital community in general. Having heard the evidence, the judges reached opposite conclusions. In Roanoke, the merger was allowed, while on February 24, 1989, seventeen months after the announcement of their intent to merge, Rockford Memorial Hospital and Swedish-American Hospital learned that the U.S. Justice Department had won its suit against their consolidation.

U.S. District Court Judge Stanley Roszkowski issued a permanent injunction against the proposed Rockford consolidation. The judge summed up his decision saying, "As previously discussed, the merger is likely to hurt consumers, as by making it easier for the hospitals remaining in the market to collude, expressly or tacitly, and thereby force prices above or further above the competitive level. . . . When analyzed in the context of the case law . . . it is unescapable [sic] that the effect of the proposed merger of RMH and SAH would be to produce a hospital controlling an undue percentage share of the relevant market, and result in a significant increase in concentration of firms in the market, so as to be inherently likely to lessen competition substantially."

In a joint statement issued following the judge's decision, Robert Henry, M.D., CEO of Swedish-American and H.W. Maysent, CEO of Rockford Memorial called the ruling "a tremendous setback to the health care delivery system in this area. We are greatly disappointed that the court did not agree with our position that the consolidation between our two hospitals would enhance rather than diminish competition."

Robert Bloch, chief of the professions and intellectual property section of the antitrust division of the Department of Justice in Washington, emphasized that the Justice Department is not focusing its actions on the hospital industry. The Department looks at all mergers of a certain size and the decision to bring suit is individual. "We are concerned as a policy matter," he said, "that health care costs in this country are 12% of the GNP. It is extremely important to insure that competition is vigorous, leading to more efficiency and better quality."

Asked to comment on the *Rockford* and *Roanoke* outcomes, Bloch said, "The two judges looked at the problem differently. The *Rockford* opinion is a classic antitrust analysis of a merger. The judge concluded that

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CHIP launched at a fast clip

MEDICALLY HIGH risk persons who hope to participate in the state's Comprehensive Health Insurance Plan (CHIP) have three important dates to circle on their calendars next month. Applications for CHIP coverage will be available April I. They will be due back by April 21. And if the number of applicants exceeds the 4000 available slots, the first insureds will be selected by lottery April 28, and notified soon after.

The mechanics

Illinois legislators established CHIP in 1988 to provide health insurance for medically high risk persons who could afford but not obtain it. Policies will be available to Illinois residents who are ineligible for Medicaid and can prove that insurance companies have rejected them for coverage due to a pre-existing condition. Those who have been offered substantially similar coverage at a rate exceeding that of CHIP because of a pre-existing medical condition will also be eligible. The Board has identified 32 "presumptive conditions" for which eligibility is granted automatically.

Mutual of Omaha has been selected by the CHIP Board to administer the program. According to George Marvin, Mutual of Omaha's administrator for state health plans, reimbursement will be at standard usual, customary and reasonable rates. Pre-existing conditions are covered six months after the effective date, unless applicants elect a special "buy-down" surcharge. Options include maternity benefits and supplemental Medicare coverage. And a lottery mechanism will ensure equity if demand exceeds program limits.

Long-term viability

The CHIP board signed off on policy format and content at their February 27 meeting. A $5.8 million start-up appropriation voted by the legislature January 10 of this year will secure initial policies. The governor's proposed budget calls for $12 million to carry the program from July 1, 1989 to June 30, 1990. Illinois Governor James R. Thompson's celebrated reluctance to sign the enabling legislation was tied to concern about fiscal responsibility, a theme he underscored in his State of the State address last month.

"The potential irony of starting such a program on April Fool's Day should not be lost on any of us," he said then. "It would be cruel joke, indeed, to start this program on April first only to end it on June 30th. That will not happen. Even though no provision has been made for funding after this fiscal year, it must and will be funded."

According to CHIP board member Howard Bolnick, who chairs the ad hoc finance committee, the program structure is actuarially sound. That fact, he says, supports his "cautious optimism" about long term viability. "The legislature didn't want to commit to an unlimited entitlement program, and it was very responsible for them to put a cap on it so it would grow as we learned," he said. "Politically, it would be extremely difficult to stop the program once it's been started. They have a moral commitment to the people in the program."

Bolnick, who is president of Celtic Life Insurance Company in Chicago and also an actuary, said that data from other state and private programs enabled the Board to determine how many policies could be funded within the constraints of the enabling legislation. Actuarial analysis set the enrollment cap of 4000 initial policies and an equitable premium structure.

"The issue of the enrollment cap starts with trying to figure out what the cost per enrollee will be," he said. The legislature had mandated that premiums be set at 135% of the open market cost for individual and small group health insurance in the state. The board studied that data, and set an average premium of $2926 per person.

"The claims and expenses of running the program will average $5845 per enrollee," Bolnick said, "which means we have a deficit of $2919 per person. We know we have $5.8 million available, and when you work out the expenses, we can enroll 4000 persons."

According to Ray DeFilippo, another CHIP Board member who serves on the finance committee with Bolnick, the law spells out the level

(continued on page 8)

Premium Costs Under CHIPS: Four Profiles



J. Smith
Age: 52
Address: Peoria (zone B)
Deductible: $500.00
Annual Premium: $2867



M. Brown
Age: 35
Address: Champaign (zone A)
Deductible: $1000
Annual Premium: $1500

L. Wilson
Age: 49
Address: Joliet (zone C)
Deductible: $500
Annual Premium: $3126



T. Murray
Age: 43
Address: Chicago (zone D)
Deductible: $1000
Annual Premium: $2257

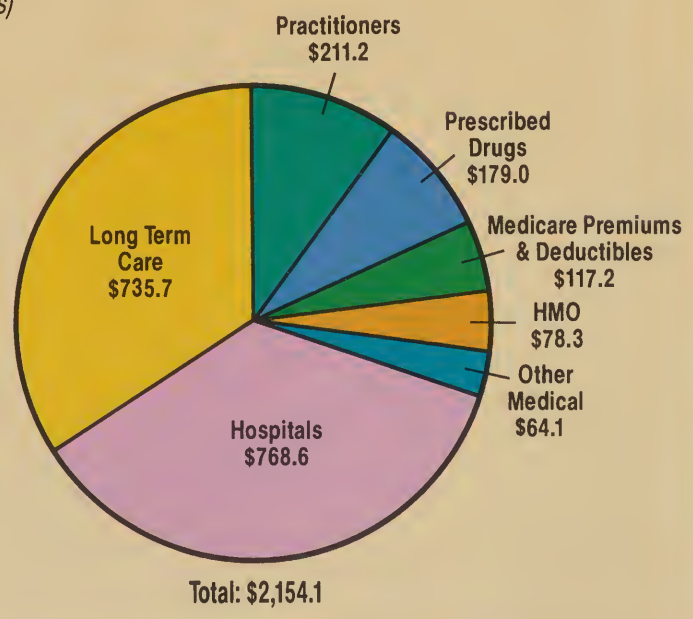


Full information is available from carrier. Rates were set at 135% of open market costs. Source: Tillinghast, A Towers, Perrin Company

Illustrations by Dan Brennan

Physician Facts

DEPARTMENT OF PUBLIC AID
Medical Assistance Payments FY 1990
(Dollars in Millions)



Source: Proposed Illinois State Budget, Fiscal Year 1990

Budget

(continued from page 1)

providers have also complained about underfunding.

Although the proposed appropriation hike is small—only .5% greater than last year's—the new funds will enable the Illinois Department of Public Aid (IDPA) to maintain all current programs, and even expand coverage of some crucial ones, according to the IDPA budget narrative.

Targeted for modest increases are several essential Medicaid programs now plagued by inadequate funding. The agency's recently-begun OB/GYN initiative would be expanded statewide. That program currently supplements payments to OB/GYNs in specified areas of Illinois where pregnant women have experienced problems finding doctors to provide prenatal care and delivery services. Lack of access to these services has reached crisis proportions in some Illinois locales, where reimbursement for complete prenatal, vaginal delivery and postnatal care is only $447.

Another area tapped for expanded funding is IDPA's preventive program, called "Healthy Kids." The proposed budget notes that IDPA will use $1 million to "increase the payment rate for tests that detect early developmental problems and for therapies to treat those problems."

A small increase in rates paid to medical providers serving public aid patients is also on the drawing board. "In order to encourage access to medical care, . . . rates will be increased for services purchased from other medical providers, including medical practitioners, hospital ambulatory care facilities pharmacists and other noninstitutional providers," says the proposed budget plan. The current Medicaid payment for an established patient's routine office visit is only $12.65.

Budgetary politics

All changes should take effect September I, 1989 if Thompson's budget is approved by the state legislature. The "if" is a big one, however, since budget and tax battles have marred the last days of Illinois legislative sessions for the past several years. Unlike prior years, Thompson has not at this time proposed a general income tax increase to fund his budget proposal. He has suggested a new I8 cents per pack tax on cigarettes. The governor says that expanded economic growth will also increase state coffers through added tax dollars flowing in.

But that might not be enough to assuage Democrats, whose leaders have voiced concern about the lack of any cost-of-living increase budgeted for welfare recipients themselves. "Speaker Madigan and House Democrats are looking to provide cost-of-living increases to recipients," said Steve Brown, press secretary to the House Speaker. "That doesn't mean we're deadset opposed to provider increases," he noted. "But we're looking for some equity."

(continued on page 3)

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Mandatory Assignment

(continued from page 1)

million in 1987," by failing to always accept assignment. "We are organizing meetings with legislators in their home districts and telling them this must be a top priority," said Council president Jerry Prete. While conceding there are inequities in the system that have prompted joint lobbying with AARP and physician organizations, AARP representative Charlotte Smith emphasized "two wrongs don't make a right."

ISMS' opposition to mandatory assignment is based on two principles, says ISMS Trustee Arthur Traugott, M.D., who chairs the Society's Third Party Payment Processes Committee. "First, the legislation is clearly unnecessary due to the large number of Illinois physicians willing to consider accepting assignment on a case-by-case basis. Second, we believe that those who can afford it, regardless of age, should pay their share at rates regulated by the government."

If approved, any Illinois physician charging senior patients more than Medicare's "reasonable amount" would be subject to prosecution under the state's "Consumer Fraud and Deceptive Practices Act." In addition, a physician's violation of any state law is grounds for licensure discipline under Illinois' Medical Practice Act. ▲

Budget

(continued from page 2)

Judy Erwin, a spokesperson for Senate President Philip Rock said that Rock doesn't believe Thompson's budget meets the state's needs as they relate to health care, education and mental health. "Rock has been the only one of the four legislative leaders to consistently support an increase in the state income tax," she indicated. But she did not say what specific position Rock will take on the public aid budget proposal.

ISMS President Harry Springer, M.D. offered another perspective on the issue. "Doctors have for many years given more than their share of pro bono care for indigent patients. But continued legislative neglect has crippled the medical community's ability to handle Medicaid's increasing load. That's why we see the governor's proposed budget as a major step forward to help assure that public aid recipients have greater access to physicians. A responsible legislature must take action."

Other health care funding

A variety of other state agencies are slated to receive additional funds for health care, if Thompson's budget makes it through the legislative process intact. The Illinois Department of Public Health would earn almost 15 percent more in funding, to be allocated primarily to programs targeted for needy women, children, AIDS prevention, and public education about unhealthy lifestyle choices.

A $50 million appropriation for a multi-pronged, multi-agency attack on drug abuse is built into Thompson's budget blueprint. Focus areas include intensified prevention, treatment and law enforcement efforts.

Thompson has granted Illinois' Department of Mental Health and Developmental Disabilities $84.6 million in new funds, much of which will go toward moving mentally ill out of nursing homes in compliance with federal legislation. ▲

More charges fly: consumer group targets medical malpractice insurers

Illinois physicians and their malpractice insurers also took heat from a consumer organization charging that companies are reaping excessive profits in Illinois' malpractice marketplace. In a late-February Springfield news conference, the Illinois Public Action Council (IPAC) called on the Illinois Department of Insurance to "conduct a comprehensive and thorough claims study" similar to one conducted by Minnesota's Insurance Commissioner that received national attention on a recent edition of ABC television's "Nightline." According to IPAC, the Minnesota study concluded that, "beyond a shadow of a doubt, recent malpractice insurance premium increases are not a result of higher insurer costs."

"There are no excessive profits to be made in Illinois' costly litigation system," responded Illinois State Medical Society President Harry A. Springer, M.D. According to ISMS, the experience of the Society's affiliated medical malpractice insurance company, the Illinois State Medical Inter-Insurance Exchange, is diametrically opposed to IPAC's claims.

While IPAC suggested that the Exchange's increase in total premiums indicated foul play, the medical society countered that total premiums can easily rise without a rate increase as more policyholders sign up with the company. "The base rate upon which Exchange premiums are calculated rose 30 percent in 1985—prior to tort reform," according to the ISMS rebuttal. Since then there has been no increase, a fact which the medical society says "reflects the stability which reforms brought." In 1985, IPAC joined with Illinois trial attorneys to oppose ISMS-sponsored tort reforms. The organization continues to voice opposition to caps on noneconomic damage awards. ▲

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

MEDICARE NOTES

Billing For CRNA Services

Services furnished on or after January 1, 1989, by Certified Registered Nurse Anesthetists (CRNAs) and certain Anesthesia Assistants (AAs) are reimbursable under Medicare Part "B" on the basis of a fee schedule. Independently practicing CRNAs and AAs may bill Medicare B directly for their services, or payment may be made to a qualified physician, hospital, or ambulatory surgery center employer. CRNAs/AAs in independent practice must obtain individual provider numbers to bill Medicare B. Employers of CRNAs/AAs must obtain a single provider number to cover all of the CRNAs/AAs in their employ.

The following instructions apply to claims filed to Medicare B for CRNA/AA services:

1. Payment for CRNA/AA services is made only if assignment is accepted, and the payment is subject to the usual Part B deductible and coinsurance. Except for the deductible and coinsurance amounts, any person who knowingly and willfully bills a Medicare beneficiary for services of a CRNA/AA is subject to civil monetary penalties.
2. Separate, assigned claims should be submitted for CRNA/AA services. The Part B billing number for the CRNA/AA services shosuld be entered in field 31 of the HCFA-1500 claim form.
3. List in field 24.C of the HCFA-1500 form the HCPCS/CPT-4 procedure code for the surgery performed during the anesthesia service. (Note: Effective for dates of service on or after March 1, 1989, claims should list the procedure codes from the anesthesia section of CPT-4. For dates of service until March 1, continue to use CPT-4 surgery procedure codes).
4. The procedure code *should not be modified* for the patient's *physical status* when billing CRNA/AA services. No additional allowance will be made to CRNA/AA services for any risk associated with the patient's physical status.
5. The procedure code *must be modified* to show whether the CRNA/AA services were *medically directed* or *not medically* directed. The modifier "X8" indicates that the CRNA/AA was medically directed. Modifier "X9" states that the CRNA/AA service was not medically directed.
6. Time units for CRNA/AA services will consist of 15-minute increments, as is the case for physicians personally performing anesthesia services. (Important note: For physician medical direction claims on or after January 1, 1989, time units will consist of 30-minute increments whether or not the CRNAs/AAs were physician-employed. Also for concurrent medically directed anesthesia procedures furnished on or after January 1, 1989, there is a 10 percent reduction for base units for cataract and iridectomy anesthesia.)
7. The type of service in field 24.G is "7" for anesthesia.
8. CRNAs/AAs are not to bill separately for CVP catheter and/or arterial lines because these services will be taken into consideration in setting the CRNA/AA conversion factors.
9. If the anesthesiologist and CRNA or AA perform anesthesia at the same operative session for the same beneficiary, only the anesthesiologist is considered to have performed the service and therefore only the anesthesiologist may bill for the service. Payment for CRNA/AA *and* anesthesiologist services can be made only if the claim provides documentation of the medical necessity of both CRNA and anesthesiologist services.
10. No payment will be made to operating surgeons for medical direction of a CRNA or AA. The CRNA/AA service in this situation should be billed, and reimbursed, as a non-directed anesthesia service.

The Part B payments currently being made for CRNA/AA services are considered to be interim payments, subject to possible retroactive adjustment after final regulations on reimbursing CRNA/AA services are published. Applications for CRNA/AA provider numbers should be made to:

Blue Cross and Blue Shield of Illinois
Medicare B — Provider Unit
P.O. Box 994
Marion, IL 62959

(This report is a service to the physicians of Illinois)
3/17/89

Editorials

Mandatory assignment: a bad idea

Mandatory Medicare assignment is riding into the Illinois General Assembly on a wave of misleading and seductive propaganda. Our legislators are facing emotional and inaccurate arguments, made stronger by the support of the influential American Association of Retired Persons. The tide will be unpopular to resist unless their constituents—physicians and patients—show them why mandatory assignment is unnecessary and ultimately harmful.

Medicare is a federal program that is, and should be, regulated by the federal government. A fact the bill's proponents consistently fail to mention is that when a physician does not accept assignment on a claim, the federal government still imposes a cap on his or her charges to the Medicare patient. And in no case can a physician charge a Medicare patient a higher rate than that normally charged other patients.

Assignment is already working in Illinois on a voluntary basis. Physicians here regularly accept the assigned rate for their senior patients who cannot afford to pay—in fact, a whopping 68 percent of all physician Medicare claims are voluntarily assigned.

What the new state law would do is make it illegal for a physician to charge any Medicare patient—even a patient who can well-afford it—the limited amount permitted by the federal government. When those who can afford it do not pay for their medical care, it just increases the financial burden on those who always pay.

Physicians do not have an easy job ahead of them. Medicare is confusing to patients, legislators and even doctors. The misleading "facts" and outright falsehoods being spread by the bill's proponents only muddy the waters more.

The best way to help everyone understand the truth about Medicare is through conversations between physician and patient, constituent and legislator. Call. Write. Sit down and talk, one on one. And rally your patients to do the same.

The U.S. Congress has repeatedly rejected mandatory Medicare assignment; patients and physicians must let lawmakers know that mandatory assignment is not needed in Illinois either.

On medicine as a business

Recent court cases on antitrust grounds have sent an unmistakeable message to the medical profession: The government now categorizes health care institutions and individual physicians as competitive business entities ripe for antitrust regulation and prosecution. The February 28 court decision blocking the merger of Rockford Memorial Hospital and SwedishAmerican Hospital is one example of government's activist stance. The 1988 Supreme Court decision in *Patrick vs. Burget,* in which peer review participants were ruled open to antitrust lawsuits, is additional evidence. Government's aggressive steps into the health care arena have reinforced the link between health care and big business in the minds of the public. Indeed, there is a growing perception of the preeminence of the "business" of medicine over the "healing profession," which endangers and undermines the traditional relationship of goodwill and trust between patient and physician.

Alternative delivery systems, new technology, increasing specialization and a host of other factors have contributed to a public view of physicians as impersonal technocrats, and to uncertainty about the relationship between physicians, patients and society at large. We are a profession—not merely a business. Patients need to know that. We must stress ethics, and rededicate ourselves to building a strong, mutual relationship between patient and physician that supersedes economic considerations. Physicians can best refute attacks on our profession—and our personal motives—by preserving and enhancing the interpersonal relationships we have with our patients. ▲

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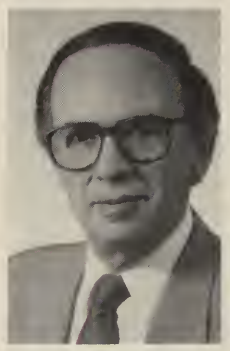
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". . . Allright, . . . Stop screaming. I'll turn off the medical tapes . . ."

President's Column

No time to relax



Harry A. Springer, M.D.

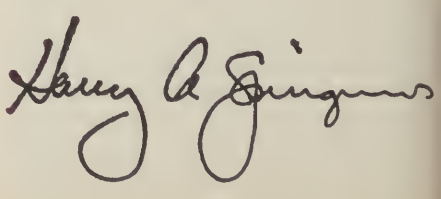
With the conclusion of the recent national elections and the launch of legislative sessions in Springfield, many people are content to watch with passive interest as the political scene unfolds. Physicians, however, cannot afford that detached posture, since many issues of critical importance to medical practice and our relationships with patients are on national and local agendas. Without reasoned, constructive input from physicians, we must anticipate that more damaging assaults on the medical profession will be listed as "wins" on the scoreboard when legislators adjourn. Obviously, this is no time to sit back and relax.

During this Congressional session, it is likely that physician fee restructuring will be part of the entire Medicare reimbursement debate, and physician reimbursement will also be among the expenditures targeted for reductions to meet Gramm-Rudman requirements. Prohibition of physician self-referral is another pending piece of federal legislation. On the state level, we know that a mandatory assignment bill for physician fees has again been introduced, after a failed effort by legislators two years ago. Health issues will also be prominently featured on the Illinois legislative schedule, with AIDS and indigent care as hotly contested items.

These are all vital issues, with far-reaching significance for society. Certainly, legislators in Washington and Springfield can be expected to carry out their designated responsibilities to weigh the issues and vote upon them. What, then, is our responsibility as constituents who will be most affected by the outcome? It is foolhardy to sit back as the "silent majority" and wait for media news reports about the results before voicing our opinions. There is simply too much at stake.

Some perceptive physicians have long known that the political process responds positively to active involvement from individual practitioners and professional associations. Physicians can have an influential voice in deciding the most important health care issues of our century. Sitting back and complaining about the results after the legislative sessions are over is futile. And it is important to remember that unfavorable legislative outcomes will force physicians and patients to cope with the long-term consequences in discomfort and frustration.

ISMS is fortunate to have so many members who can persuasively articulate the issues and suggest effective solutions to legislators. Accordingly, I encourage each ISMS member to accept responsibility for taking an active role in the political process of shaping the future of health care. We cannot afford to let others do the job for us, since we will have to shoulder the blame of passivity which causes the unsatisfactory outcome. ▲



Harry A. Springer, M.D.
President
Illinois State Medical Society

Chicago trauma network status reflects good coverage overall, but cost issue echoes again

by Janice Rosenberg

MEDICAL EXPERTS agree that trauma centers save lives. They also concur that participating hospitals experience large financial costs. The Chicago trauma system, begun May 1, 1986, originally included ten hospitals designated as level one trauma centers: Illinois Masonic Medical Center, Michael Reese Hospital & Medical Center, Northwestern Memorial Hospital, Children's Memorial Hospital, the University of Chicago Hospitals, Lutheran General Hospital, Loyola University Medical Center, Christ Hospital and Medical Center, Louis A. Weiss Memorial Hospital, and Cook County Hospital. Mount Sinai Hospital Medical Center was added on March 5, 1987.

Each hospital was designated a level one trauma center for a two year period. In May 1988, Weiss and the University of Chicago chose not to renew their designations due to heavy financial losses associated with trauma center status. Michael Reese Hospital, scheduled to withdraw from the system January 15, 1989, agreed to remain an additional two months or slightly longer. A Michael Reese spokesperson confirmed in early March that while a specific termination date had not been set, they would be forced to withdraw from the trauma network in the near future if additional reimbursement is not made available. These events have prompted concerned individuals to take a new hard look at the two and one half year-old system.

John Barrett, M.D., director of the trauma unit at Cook County Hospital and project medical director of the Chicago Fire Department, is not surprised that hospitals have dropped out. "We expected a certain amount of attrition when the system was created," he says. "Once people get into the business of trauma centers they realize that they lose money hand over fist. They all knew this before, but didn't realize how bad it would be."

Dr. Barrett believes that, even with the Michael Reese withdrawal, the system will have enough centers. National figures suggest that a trauma center should handle 600-1000 seriously injured patients per year. A population of 750,000 will supply this volume of patients. Based strictly on Chicago's population of approximately four million, the city needs five or six centers.

Criteria for efficiency

But going by the numbers alone does not necessarily assure efficiency. Dr. Barrett describes a trauma system as consisting of three compo-

(continued on page 10)

CARAFATE®
(sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other Issued 1/87

Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987; 9(4):395-399.

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CAFAD276 Please see brief summary of prescribing information, and reference on adjacent page. 0160N8

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled the following case?

Presenting complaint—None. The individual went to a physician designated by a potential employer for a pre-employment physical.

Subsequent diagnosis by another physician—Cancer of the thyroid.

The case in brief—This case demonstrates liability issues that can arise when one physician follows up a possibly serious medical problem which another physician identifies during a routine pre-employment physical examination. Here is what transpired.

During the process of a physical examination required to certify a man's fitness for a job as a fireman, the examining physician, employed by the fire department for the task, noted a nodule in the man's thyroid area. Before fully certifying that the man was healthy and could take the fireman's job, the examining physician referred the patient to his family physician for evaluation of the nodule. The patient's family physician ordered a thyroid scan and received a report that it showed a bizarre-appearing, cold nodule. He told the patient the thyroid should be removed and informed the fire department that the scan did not suggest cancer.

In less than a year, the patient experienced swelling in the neck area and he consulted another physician. That physician diagnosed thyroid cancer, hospitalized him, performed a total thyroidectomy and a modified neck dissection. Following surgery, the patient underwent radiation therapy. Subsequently, he also underwent a vasectomy because he feared possible adverse effects of the radiation, should he father any additional children. The tumor recurred one year later and was removed. Several years have elapsed and there has been no recurrence.

The resulting claim—The patient sued the family physician for misdiagnosis of his thyroid cancer.

The outcome of the claim—A $90,000 settlement was negotiated on behalf of the defendant physician.

Why problems arose with this case—The family physician failed to move swiftly to confirm and treat the patient's problem. He did not order a confirmatory biopsy of the nodule. Although he advised the patient that the thyroid should be removed, the patient testified that the physician did not tell him why surgery was necessary or suggest that the surgery be performed immediately, but told him that he "had nothing to worry about." Because the physician did not move aggressively to treat, the patient eventually underwent far more radical surgery than might have been necessary. The patient also said that because he had to have radiation, the subsequent vasectomy meant he and his wife could have no more children. He said they wanted other children because their only child was mentally impaired.

The points this case makes—When a patient presents with a symptom that could suggest a serious problem, the diagnosis should be confirmed quickly, using the appropriate tests and procedures. No assurances should be given until the results are in and a diagnosis established.

- Delay in or failure to follow-up a patient's problem can allow it to become more serious and necessitate more drastic treatment later on. The more extensive surgery in this case led to some physical disfigurement that might have been prevented. Although radiation therapy might have been necessary in any case, the fact that the patient decided to undergo a vasectomy which precluded fathering other children was a significant secondary factor in the liability action.
- Assurances, even though well intended, that there is no problem or that it is minor before confirmation by tests could expose a physician to liability on breech of warranty grounds.
- Break-downs in communications exacerbate liability. Perhaps what the patient heard and what the physician actually said were quite different. Clear, specific explanations and instructions by the physician are always important in any doctor-patient encounter. Written as well as verbal instructions help assure that the patient will follow instructions.

Was the physician who did the pre-employment exam free of liability?—Yes. A physician who performs a pre-employment physical exam has an obligation to inform the person being examined if he finds any serious or potentially life-threatening problem, and to advise him/her to obtain further medical care. In this case, the examining physician fulfilled his obligation fully to the patient. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *I am planning to retire from full-time practice, but may wish to practice part-time, or resume full-time practice sometime in the future. Will I be able to reactivate my ISMIE policy?*

A: Exchange policy defines retirement as "attaining the age of 55, and the conclusion of and complete withdrawal from one's working or professional career as a physician." Physicians 55 years or older who have been insured by the Exchange for a minimum of five consecutive years, and are retiring in accordance with ISMIE policy, are entitled to a Reporting Endorsement without an additional premium charge. Once the Reporting Endorsement has been issued on this basis, we expect the physician's withdrawal from medical practice to be complete and irrevocable, precluding our ability to resume coverage. Physicians who are unsure of their future plans may choose to reduce coverage to part-time (25 percent) by electing a rating of "Retired, Not in Practice" or "No Clinical Practice." This will allow the policy to continue while plans are being clarified. The part-time (25 percent) coverage options limit the physician to the uncompensated treatment of friends or relatives only, and allow the physician to pursue an administrative position for which ISMIE coverage is not required. Physicians may also elect suspended coverage of their policy for a minimum of three months and maximum of one year. Physicians who are considering retirement are strongly encouraged to discuss their options with an Exchange underwriter before reaching a final decision.

Q: *What is a corporate registered agent and why is it important that the agent be located where I practice?*

A: A corporate registered agent is the individual, either an attorney or a member of the corporation, selected or designated to handle the corporation's business affairs. It is to the physician's advantage that registered agents be in the county where the practice is located to avoid claims or suits being filed in more than one county. If the agent is located in the same county as the practice location, no further action is needed. However, if the registered agent is located in a different county, the Exchange strongly advises seeking a registered agent who is located either in the county of the practice location, or in the county of the physician's residence. The only exceptions to this advice are physicians who practice in Cook County whose agents are in DuPage County, or physicians practicing in Cook or Lake Counties whose agents are in McHenry County.

Q: *I want to introduce a weight reduction program into my practice. Am I covered for this activity?*

A: Physician requests for weight reduction program coverage prompted a recent review of this issue by the ISMIE Board of Governors. Physicians who desire to introduce a weight reduction program into their practice are advised that such programs are *not* automatically covered. Therefore, they are requested to notify the Exchange in writing before implementing such a program. Each request will be given individual consideration. Physicians desiring coverage for weight reduction programs will be asked to provide written evidence of training in the use of a particular supplement, as well as a description of a behavior modification component. In addition, physicians are advised that the Exchange cannot insure a physician who participates in more than two such programs. ▲

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Winnebago County Auxiliary: there when you need them

by Karen Sandrick

SOMETIME THIS year, Winnebago County will become one of the first communities in Illinois to have enhanced 9-1-1 emergency telephone service. That important reality is largely because of the efforts of the Winnebago County Medical Society Auxiliary.

The auxiliary's interest in securing enhanced 9-1-1 service began tragically when, in August 1987, the 18-month-old daughter of Dr. Marc and Kris Carlson died of drowning while the couple's seven-year-old child tried in vain to obtain emergency help via Winnebago County's complicated emergency telephone system.

Winnebago County residents must dial one seven-digit number for the fire department and another for the police. These numbers differ in Rockford, which is served by the city's fire and police services, and in outlying areas, which are served by the county sheriff and volunteer fire departments.

"We felt that if we took the health point of view, we could make the voters aware that critical time was being lost in an emergency, when seconds count in getting some kind of help."

Although most households have telephones programmed with emergency numbers, precious time may be lost if someone does not know the program, if one or more phones in a residence are not programmed, or if a child, like the Carlson's seven-year-old, has difficulty dealing with a program.

The medical society's auxiliary saw enhanced 9-1-1 as a health issue. They mobilized first to urge local politicians to take action. Members of the auxiliary distributed petitions to political representatives and testified at hearings before the Winnebago County Board and four municipalities. Largely as a result of these activities, the county included on the March 15, 1988 primary election ballot a referendum asking citizens to decide whether they would be willing to pay a surcharge to support a countywide enhanced 9-1-1 system.

The auxiliary then began a massive campaign to educate the community about enhanced 9-1-1 service, which not only allows residents to call one easy-to-remember number for all emergencies but also displays on a terminal screen the caller's phone number and location. This vital information will not be lost should the caller inadvertently hang up. The system also can forward calls to special support services—poison control or suicide prevention, among others—with a touch of a button.

"We felt that if we took the health point of view, we could make the voters aware that critical time was being lost in an emergency, when seconds count in getting some kind of help," said Carolyn Lowry, auxiliary health projects chairwoman.

Under the direction of Karen Girardy, then-president of the auxiliary, and Lowry, auxiliary members developed and distributed 90,000 leaflets to churches, grocery stores, doctors' offices, and hospitals; hung 3,000 posters in clinics, restaurants, shopping centers, and business offices; and put up 400 yard signs during an intensive "Vote Yes on 9-1-1" campaign. Some members appeared on local radio and television programs and spoke at over 25 city and village meetings and church and senior citizens' gatherings.

It is a measure of the auxiliary's success that the referendum passed by 70% in Winnebago County when 9 of 15 other communities defeated similar referenda on the November 8, 1988 ballot. In fact, the chairman of the Illinois Commerce Commission and the Winnebago County Board called the auxiliary's leadership pivotal to passage of the 9-1-1 measure.

The auxiliary's work still is not over. Lowry is an active member of the county committee that oversees the engineering and purchase of new telephone equipment. She regularly mails educational materials to communities as far away as Virginia and South Carolina so that individuals like the Carlsons will not lose a loved one to delayed emergency care. ▲



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(continued from page 2)

of benefits, and premiums are tied to area of residence, gender, age, and deductible. "The CHIP Board retained consultant actuaries with broad experience in the health field," he said. "The premiums are projected to create a deficit and that's where the state subsidy comes in."

Optional benefits

As with any insurance policy, applicants can select from a menu of coverage options. It is expected that the "buy-down" and Medicare supplemental will be among the more popular opportunities.

Illinois Department of Insurance Assistant Deputy Director Lloyd Rice explained that the buy-down option, which is in some cases a great benefit, should be exercised advisedly. The "buy-down" clause permits policyholders to reduce the waiting period for coverage from six months to two months by paying a 10% surcharge for the life of the policy. Surgical costs are excluded. "There's a catch-22 in that when a person buys down, surgery and expenses related to that are not available until after the sixth month," Rice said. "If a person is hospitalized, that's covered, but not surgery." The option is available only for the first year of the plan, Rice said, but the surcharge will apply for the life of the policy.

Board members agree that supplemental Medicare coverage is more affordable on the open market than through CHIP. But CHIP could be a significant boon to under-age 65, disabled Medicare recipients, who cannot obtain supplemental Medicare policies written for the over-65 population on the open market.

"We calculate what the person will get in terms of benefits under our policy, and subtract what Medicare will pay," Bolnick explained. "By buying our policy they are assured of CHIP benefits, and there's a 50% premium discount to the Medicare-eligible patients.

Cost will limit enrollment

While CHIP coverage is also to help those who can obtain commercial health insurance only at exhorbitant cost, the CHIP itself is not inexpensive. "In other states, the high cost of coverage has been a barrier to entry," Bolnick said. "Not a lot of people have been able to take advantage of the program. In the long run, we'd like to see a viable program that was serving more than a limited number of people. The number of people who need this program will undoubtedly exceed the number who will be able to take advantage of it."

According to Elaine Hirsch, Illinois Attorney General Neil Hartigan's designee on the CHIP Board, thousands of Illinois citizens anxiously await the opportunity to make that investment. Hirsch's responsibilities in the department of citizen rights for the attorney general brought her into contact with a disabled population which clamored for relief.

"When you sit where we do and you listen to the phone calls and you read the letters, you come to understand the people," she said. "These are people who can't take a terrific new job because a new employer won't cover their child. If you're the mother of a kid with juvenile diabetes and you can't get any insurance to cover it—you'll pay a little extra."

"We've been working on this for four-and-a-half years," Hirsch said, "and we've kept a separate list of people who've called about only the CHIP. That list numbers over 10,000 already."

Where to direct patients

Physicians with patients who might be eligible for the CHIP should urge them to act quickly, as the enrollment cap could be reached with the initial offering.

"All applications which are received, with the appropriate premium enclosed, by the administrator no later than 4:30 p.m. on Friday April 21 will be considered to have been received at the same time," according to Marvin. If the total exceeds 4000, all applications will be entered in a lottery to determine which will be considered for enrollment. "This lottery will be conducted no later than April 28," Marvin said. "The earliest CHIP coverage can be effective for those whose applications are complete and accepted will be May 1, 1989."

Applications received after April 21 will be added to the waiting list on a first come-first served basis. If less than 4000 applications are received by deadline, Marvin said, all would be enrolled and subsequent applicants enrolled on a first come-first served basis until the 4000 enrollment cap is reached, at which time the waiting list comes into play.

DeFilippo, who is director of group and health insurance for the Country Companies, said that the CHIP board plans a one-time mass mailing to all licensed insurance producers (or agents) in Illinois. "We have almost 1000 agents in Illinois who eagerly await this because it's a means of helping their clients," DeFilippo said. "The bill provides that insurance agents who have a client turned down for health insurance are to advise them of the possible availability of medical coverage through the Illinois CHIP program."

According to Marvin, those who wish to be added to the initial mailing list for applications can contact the local administrative office by writing: Illinois CHIP, Box 20, One Westbrook Corporate Center, Westchester IL 60154. A toll free number (1-800-456-0224) is also available. ▲

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ANNUAL MEETING 1989

DELEGATES ATTENDING the 1989 Annual Meeting of the ISMS House of Delegates Friday, April 7 through Sunday, April 9, 1989, will get an inside view of the national health care agenda from several respected political experts and pundits. The meeting will be held at the Westin O'Hare Hotel, 6100 River Road, in Rosemont, Illinois.

The opening session of the House will begin at 9:30 a.m. on Friday, with a 10 a.m. address by noted polling specialist Robert Teeter, founder of Robert Teeter and Associates, Ann Arbor, Michigan. Formerly president of Market Opinion Research, Teeter has conducted polls for George Bush and other political candidates.

Friday's events will be highlighted by the President's Night 1950's "Prom Party." Prom attire is optional.

U.S. Rep. Richard J. Durbin, (D-Springfield) will address the annual Public Affairs Breakfast on Saturday morning at 7:30 a.m. The public policy theme will round out with Pat Buchanan's appearance before the House later that morning. Buchanan, often named among the nation's foremost political strategists, is a syndicated columnist, and former Director of Communications for President Reagan.

District meetings will be held immediately following the close of the first House of Delegates session. Reference committees will debate resolutions Friday afternoon.

Both the ISMS Auxiliary and the Illinois State Medical Inter-Insurance Exchange will meet in conjunction with the ISMS House. The Exchange membership meets Wednesday, April 5, while ISMSA meets April 6 and 7.

The Annual Meeting is open to all ISMS members. For further information, call 312-782-1654, or 1-800-782-ISMS. ▲

Notification of IMPAC Annual Meeting

The 1989 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 7, 1989, immediately following the adjournment of the ISMS House of Delegates.

11:15 a.m. (approximately)
Westin O'Hare Hotel
Rosemont, Illinois

All members are encouraged to attend.

The 1989 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council for terms expiring in 1992. They are:

Robert D. Dooley, M.D., Hinsdale
David B. Littman, M.D., Highland Park
Mrs. Alfred (Norma) Kiessel, Decatur
Paul F. Mahon, M.D., Springfield
George T. Mitchell, M.D., Marshall
Harry A. Springer, M.D., Evanston
Patrick B. Staunton, M.D., Park Ridge
Mrs. Alan (Pam) Taylor, Danville
Robert M. Vanecko, M.D., Chicago
George T. Wilkins, Jr., M.D., Edwardsville

1989 Annual Meeting Resolutions

Resolutions

Number	Subject	Introduced by	Reference Committee
1(A-89)	Equality in Licensure and Reciprocity	James H. Andersen, M.D. Chairman, Cook County Delegation	D
2(A-89)	Amendment Chapter VI, Section 3, Succession of Vice President	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
3(A-89)	ISMS Policy Statement, Due Process	Harold L. Jensen, M.D. for the Board of Trustees	D
4(A-89)	ISMS Policy Titled, Animals in Research & Education	Harold L. Jensen, M.D. for the Board of Trustees	C
5(A-89)	AMA Delegation Officers Titles	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
6(A-89)	Funding for Health Related Problems in Illinois	James H. Andersen, M.D. Chairman, Cook County Delegation	B
7(A-89)	Amend Chapter IX, Section 8, Committee on Insurance	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
8(A-89)	Amend Chapter IX, Section 8, Building & Capital Equipment Com.	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
9(A-89)	Amend Chapter IX, Section 8, Committee on Publications	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
10(A-89)	Amend Chapter IX, Section 3, Subsection F, Organization of Councils	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
11(A-89)	Amend Chapter IX, Section 3, Subsection C, Organization of Councils	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
12(A-89)	Amend Chapter II, Section 1. Dues	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
13(A-89)	ISMS Policy Statement, Illinois Medicine	Harold L. Jensen, M.D. for the Board of Trustees	C/BL
14(A-89)	ISMS Position Statements, Mental Health	Harold L. Jensen, M.D. for the Board of Trustees	C
15(A-89)	Medical Staff Committees to Assist Impaired or Distressed Physicians	Harold L. Jensen, M.D. for the Board of Trustees	C
16(A-89)	Relief from Third Party Payors Requiring Confidential Patient Information over the Telephone	James H. Andersen, M.D. Chairman, Cook County Delegation	D
17(A-89)	Deletion of ISMS Policy titled, Statement of Understanding	Harold L. Jensen, M.D. for the Board of Trustees	B
18(A-89)	Hazardous Medical Waste Disposal	Raymond A. Dieter, Jr., M.D. for the DuPage County Medical Society	C
19(A-89)	U.S. Public Health System	Raymond A. Dieter, Jr., M.D. for the DuPage County Medical Society	C
20(A-89)	Competency for Treatment Control	Garth D. Smith, M.D., for the DuPage County Medical Society	C
21(A-89)	Temporary Trainee License	Sadiq Mohyuddin, M.D., for the Madison County Medical Society	C
22(A-89)	Liability Coverage for County Medical Society Office Bearers	Sadiq Mohyuddin, M.D., for the Madison County Medical Society	A
23(A-89)	Dichotomy of Cost-Effective Care and Potential Law Suit Defense	J. H. Gardner, M.D., for the Rock Island County Medical Society	D
24(A-89)	Alcoholic Beverage Tax to Finance Treatment of Alcohol-Related Highway Trauma	J. H. Gardner, M.D., for the Rock Island County Medical Society	D
25(A-89)	Co-Payability of Non-Assigned Insurance Checks	Richard L. Phillis, M.D., for the Rock Island County Medical Society	B
26(A-89)	Medical Assistants Articles in *Illinois Medicine*	Richard L. Phillis, M.D., for the Rock Island County Medical Society	A
27(A-89)	Comparing Health Care Systems	Joseph R. O'Donnell, M.D., for the DuPage County Medical Society	B
28(A-89)	HMO Physician Contracts	S. J. Schimel, M.D., Delegate	B
29(A-89)	Illinois Malpractice Insurance Rates	S. J. Schimel, M.D., Delegate	A
30(A-89)	Regulations of External Review Groups	Geoffrey A. Bland, M.D., for the Hospital Medical Staff Section	B
31(A-89)	Community Forum for Hospital Mergers and Closings	Geoffrey A. Bland, M.D., for the Hospital Medical Staff Section	A

Unfinished Business Reports

Report A	Medical Staff Bylaws for Outpatient Surgical Centers	Harold L. Jensen, M.D. for the Board of Trustees
Report B	Mandatory Informed Consent for HIV Testing	Harold L. Jensen, M.D. for the Board of Trustees
Report C	Eliminate Discrimination Against Patients in Health Insurance Coverage	Harold L. Jensen, M.D. for the Board of Trustees
Report D	Coalition for Medicare	Harold L. Jensen, M.D. for the Board of Trustees

EDITOR'S NOTE: Resolutions received in the ISMS offices prior to March 8 but after the Illinois Medicine *publication deadline are not listed above, but will be included in the delegates' packets.*

(continued from page 5)

nents. "You have to get the appropriate patient to the appropriate hospital in an appropriate time frame," he says.

Established triage criteria determine appropriate patients. National figures suggest that 95 percent of people who are traumatized do not need to go to special trauma centers and should be taken to the closest hospital. The triage criteria are designed to pick up the remaining 5 percent. Chicago has "tight" criteria that cover only cases involving immediate life threats (cardiac arrest, hemorrhagic shock), immediate limb threats (amputation, total or partial, at or above the wrist or ankle), or a Champion trauma score of twelve or less (a number generated by a combination of various physical signs including pulse rate and blood pressure). Paramedics assess injuries and patients who meet one of these criteria are taken to trauma centers.

Dr. Barrett criticizes the Chicago network for "under-triage." "Over the past two years our triage criteria have captured only 1.8 percent of all the trauma patients transported by the Chicago Fire Department," he says. "We need to rethink our criteria, liberalize them to match the national criteria that also include all penetrating injuries to the chest or belly, any gunshot wound to the chest or belly, and any gunshot wound to the head."

Dr. Barrett's second component, the appropriate hospital, can be defined as a hospital that meets the national comprehensive standard for immediate around-the-clock sophisticated care for life-threatening injuries. Each center's trauma service includes a trauma surgeon, emergency and medical specialists, operating rooms, intensive care, blood supply, and up-to-date lifesaving equipment dedicated to the optimal care of the trauma victim. Prior to the establishment of the Chicago trauma system, trauma victims were taken to the closest emergency room regardless of their level of service.

The final component in Dr. Barrett's scheme is that the patient reach a trauma center within an appropriate time frame. A national rule states that the patient should reach a center within 30 minutes. Dr. Barrett says that a withdrawal by Michael Reese will not affect the Chicago system with regard to time elapsed between traumatic incident and arrival at a trauma center.

"Up until now," he says, "the longest we've been taking is 20 minutes." A computerized map (designed from information collected on ambulance speeds through all types of neighborhoods) can predict ambulance travel time between any two points in the city. Barrett says the computer has shown that even without Michael Reese, the Fire Department will continue to maintain the 30 minute rule.

undated. "We plan to route more people to Cook County and other hospitals in the system," he says. "But we really don't expect any crisis to develop with Reese gone. As far as we can see the transport times will still be reasonable."

Dr. Biek does not foresee replacing Michael Reese. "In order to achieve the best results, a level one trauma center should be treating about 1000 level one cases per year. None of our centers are coming close to that. I don't think the total trauma cases have reached 3,000 per year. Theoretically, if you had three strategically located centers, you'd get the best possible results."

While City officials such as Drs. Biek and Barrett feel that a Michael Reese withdrawal will not have a negative affect on the system, not everyone involved agrees. Members of the Illinois Chapter of the College of Emergency Physicians are disturbed by the loss of two centers and a possible third over the last year. "We're concerned," says Ron W. Lee, M.D., president, "that this may represent a trend rather than a one time anomaly. We're concerned that unless the trend is reversed there'll be fewer centers in the city capable of handling the numbers of significant traumas and that they may not be located in the most advantageous places."

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

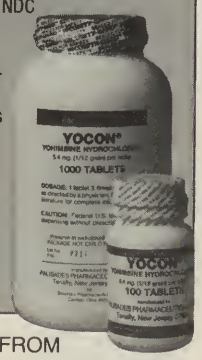
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Chicago Trauma Systems Hospitals



The south side segment of the Chicago system would be most affected by a Michael Reese pull-out. Originally that segment also included the University of Chicago and Christ Hospital. Christ Hospital is an 824-bed facility located in the suburb of Oak Lawn, just six blocks from the Chicago city limits. It is a community hospital which also provides tertiary services: a high risk nursery, rehabilitation services, and comprehensive mental health care.

"The University of Chicago's leaving had a minimal effect on us," says Carol Schneider, associate administrator for Christ Hospital, "And our expectation is that Michael Reese leaving will not change our volume of trauma patients. We think that the majority of their trauma cases will go to Cook County Hospital with a small number going to Northwestern."

Dr. Barrett agrees. "County can cope with additional patients," he says. "It's chronically underutilized, especially since Mount Sinai was designated right next door."

Deputy Health Commissioner for Chicago, Richard Biek, M.D., has already taken action that will prevent Christ Hospital from becoming in-

Financial losses greatest concern

Financial losses are the greatest concern for the hospitals involved in the system. Ivan Dee, public affairs director for Michael Reese, reports that the hospital lost an estimated $400,000 in treating trauma cases during the three months after the University of Chicago left the network. During those three months Michael Reese received 85 level one trauma patients compared to 22 such

patients in the three months preceding the University's departure.

The hospital announced that they would leave the system unless new reimbursement arrangements were worked out. "We estimated a more than $1.5 million loss over the next fiscal year," Dee said. "If the financial problems were worked out sometime in the future we would look into being part of the system again." In the meantime, the hospital will continue to operate its emergency room.

According to Bird's testimony, preliminary reports estimate that, as a group, the Chicago trauma centers will lose $18 million by the end of 1988. "It is projected," he said, "that trauma centers will spend $30 million to render care to 3,000 trauma patients. Of this, $18 million will never be received by the hospitals."

In January 1989, a computerized trauma registry began collecting data on the Chicago system. The registry was devised by Charles Sheaff, M.D., who designed a similar process that has been in use for over ten years at Cook County Hospital. The data will include the charges and type of payment mechanism for each patient.

Robert Smith, M.D., medical director for trauma programs at the Chicago Department of Health, would like to see all the hospitals in the system using the same type of accounting method to determine the costs of caring for trauma patients. He notes that the widely differing methods that hospitals now have for arriving at their per patient costs affect the validity of available figures.

Leslee Stein-Spencer, chief of Emergency Medical Services and Highway Safety for the State of Illinois Department of Public Health, sees the Chicago system's financial problems as reflecting a significant nationwide problem. Bills to get federal funding for states to provide trauma care were introduced into both the U.S. House and Senate in 1988, she said, but the House and Senate session closed before a vote was possible.

While federal funding may eventually help trauma systems, the Chicago system needs money now. Bird asked that the city take the lead in resolving this problem by providing $20 million in emergency funding to subsidize a portion of the losses faced by the private hospitals.

Deputy Health Commissioner Dr. Biek suggests that a fund-raising effort could be undertaken to establish a foundation with an endowment. "It would not take a tremendous amount of money," he says, "to be sure that just by the interest from the endowment we could cover this particular kind of loss. They've done that in other states."

Dr. Barrett believes that the designated trauma center hospitals should not expect to have complete funding for every patient. "They made a commitment to take care of trauma patients," he says, "and the designation gives them prestige. They should eat half of their losses. The other half should be reimbursed."

Dr. Barrett would like to see the Metropolitan Chicago Healthcare Council establish a fund. "Those hospitals not designated as trauma centers should contribute to the fund," he says, "because if we didn't have a system these patients would go to the nearest hospital, and the nearest hospital would lose money. The city should also kick in some money because the system is providing service to the city." Dr. Barrett believes that if something like this were done, the system would not have to worry about the loss of other centers.

This funding idea is considered invalid by Patrick Finnegan, director of emergency medical services for the Metropolitan Chicago Healthcare Council. "It may seem like a very good idea on paper," he says, "but the reality is that the hospitals who would be most impacted are the ones who could afford it least." Finnegan points out that even with the trauma system in place, smaller, non-system hospitals continue to lose money on the patients they treat in their emergency rooms. "They've already admitted that they can't handle the major trauma cases," he says. "If they can't handle them financially on their own, how can they give $75,000 or $100,000 to a fund so that someone else can handle them?"

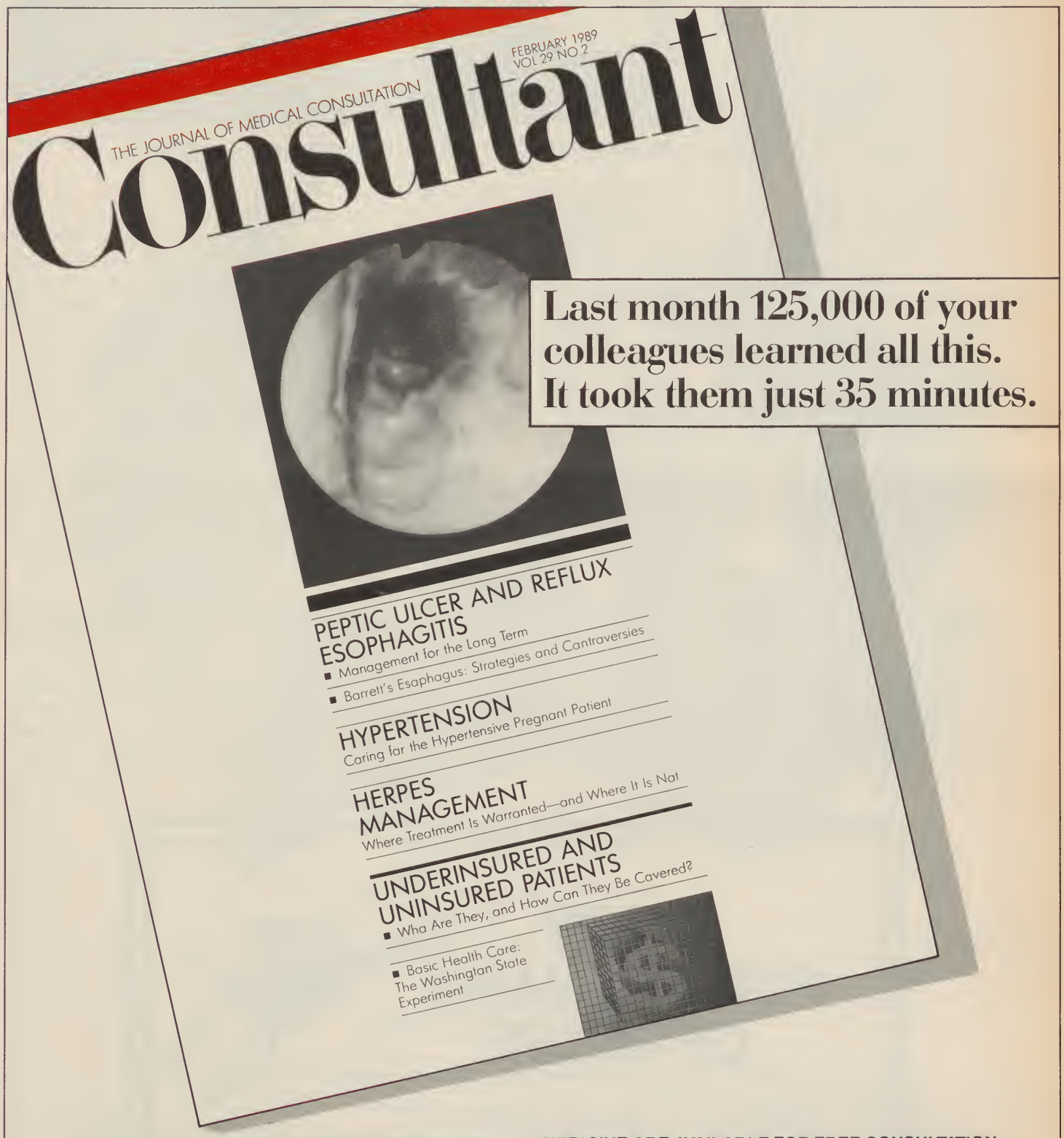
The Healthcare Council is currently working with the city department of health to find a method of funding. Finnegan sees all hospitals as having a stake in the system. "Because if the trauma center system falls apart then the hospitals that are not now centers will have to start taking care of these patients."

Dropout and financial problems aside, everyone agrees that the Chicago trauma system has worked well in providing patient care. Finnegan calls the system an excellent idea and adds, "We at the Council want to make it financially viable for hospitals to stay in."

Stein-Spencer of the IDPH, fears that the big gap in the south side sector may be detrimental to patient care, but thinks that on the whole the system has worked well.

Dr. Lee reports that the College of Emergency Physicians wants to preserve the system. "Traumatically injured patients are doing much better now with the system than ever before," he says. "We would like to work with interested parties to see that we don't lose it."

"The system is working extremely well," says Dr. Biek. And Dr. Barrett agrees that with a loosening of the triage criteria, an allowance for natural attrition, and the finding of alternative sources for money, the system can continue to save lives. ▲



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A doctor who made it gives something back

by Kevin O'Brien

In Focus



Dr. Terry Mason

Photo by The Photo Partners, Inc.

THE SCENE is a library in an old, run-down but relatively clean inner city high school. The 37-year-old doctor knows his subject. He also knows his audience—a group of 35 to 40 sophomores, juniors and seniors. He especially knows that succeeding in the day's mission requires getting their attention, and keeping it. Starting in the front of the room, he works toward the rear along one side and back down the other passing out Webster's College Dictionaries.

"The first person up here, I want you to look up the word 'acquired'," the doctor orders as he passes out the dictionaries.

"This person right here, I want you to look up the word 'immune'."

"The person back there, I want you to look up the word 'deficiency'."

"And the person right here, I want you to look up the word 'syndrome'."

This is the third of four classes in AIDS prevention that Terry Mason, M.D., a volunteer member of the newly-organized ISMS AIDS speakers bureau, will conduct at Cregier Vocational High School. Actually, most of these kids have seen Mason before. He appears in the ISMS-produced videotape, AIDS: CHOOSE TO BE SAFE, that Cregier school nurse Helen Ramirez, R.N., showed to them to prepare them for today's class. Now, he loses no time in setting some ground rules.

"There are *no* dumb questions," Dr. Mason says. "Anybody that wants to ask any question, ask it. If anybody *laughs* at any question that anybody asks, I will stand you up and embarrass the hell out of you. OK?"

Three of the students immediately busy themselves with the assignment. Dr. Mason makes sure they know how to spell the words as he reminds them to consult the guide words at the top of each page.

The boy in the back of the room, however, whose job it is to look up 'deficiency,' is not at all enthusiastic about his task, and makes sure the doctor knows it. After a brief exchange, the boy sullenly gets up, saunters down the aisle, and leaves the room. Another student resumes the search for 'deficiency.' Dr. Mason goes right on.

A couple of weeks later in his office in Printer's Row, he reflects on the experience and his method. "I thought it went well. I was trying to figure out how I was going to involve them. I didn't want it to be another lecture."

But Dr. Mason also knew he had to immediately establish his authority. Whatever the kids' peer relationships were outside of that classroom, they were not operational in this setting.

"I understood a number of dynamics that you had to deal with right away," he says. "Otherwise, once you lost control, it was over."

Dr. Mason mentions the kid who walked out. "Even that was a matter of, 'Now what do I do? Should I be more confrontational? Should I let him go and continue to deal with the rest? And then try to get him back?' "

Dr. Mason chose to let him go. Confrontation is what these kids are accustomed to. More of it would merely have drained energy that could be better channeled into more positive things. And anyway, he says, "I knew that I would get him later."

Dr. Mason is a successful board-certified urologist and co-author, with writer Valerie Greene Norman, of a new book "Making Love Again: Renewing and Helping Your Man Overcome Impotence." He is the founder and director of Not For Men Only, a program for impotent men and their partners based at Chicago's Mercy Hospital.

Dr. Mason readily agreed to appear in the ISMS video and participate in the speakers bureau. For about three years he and a gynecologist colleague have conducted sex education classes in Chicago public schools, targeting their efforts to sixth, seventh and eighth graders. Dr. Mason says they split the classes; Mason taking the boys and male teachers, and his colleague taking the girls and female teachers. That way, he explains, everyone feels comfortable enough to have a frank discussion.

Dr. Mason's explanation to the students of how the AIDS antibody works is in street terms the kids understand.

"Everybody knows what a gang is, right?" No problem, everybody knows.

He then asks whose territory this is, meaning what gang controls the surrounding neighborhood. The class tells him that it's "Folks" territory.

"OK," he continues, "what if a person who's not supposed to come into this territory, came into this territory and did something and left, what would the Folks do? The next time (someone invaded the territory) the Folks would be in a pack looking for somebody, right? Now, the Folks would be 'antibodies,' because they would be looking to seek and destroy the next time this other person came into the area. You all understand what I'm saying?"

By now, if he didn't before, Mason has their attention. Reminding them of the definitions they looked up earlier, he explains how the immune system works to prevent disease in healthy people, and then moves on to the subject at hand.

"AIDS disarms your immune system, it takes it apart, so you are no longer able to fight anything. And [so little as] a common cold can kill you. So the people with AIDS have to be more afraid of you, than you of them."

It is very effective stuff. A lot of these kids give the impression they would rather be anywhere than in school. But by talking about AIDS in their language, Dr. Mason connects. When he talks about death, about the terrible and ultimate finality of AIDS, the proverbial pin could drop and it would shatter the stillness of the room like a gun shot. The kids don't move, they don't talk—they listen. Gradually, they understand.

Mason speaks their language because he's been there. He came from a broken home and has nine siblings, four of whom he didn't know until he was 19 years old. He grew up in the '60s in the Englewood community, which was and is one of the most economically and medically deprived areas of the city. He went to three different Chicago public grammar schools and graduated from Chicago Vocational High School in 1969. His mother had a fifth-grade education and made a living as a maid in what was then known as the Jackson Park highlands.

Dr. Mason says that many of the clothes that he and his siblings wore came from the children of the families his mother worked for. Others came from boxes of old clothes she would acquire at rummage sales.

"But she had a very strong work ethic," Dr. Mason says. "And a very intense drive that was transmitted to us about always having your own, and always being independent."

Dr. Mason credits a series of mentors for his eventual success, starting with a man named Joseph Bingham, who owned a grocery store across the street from where he lived. He says that before Bingham, he had never heard an articulate black man.

"He was only educated through the 12th grade," Dr. Mason says of

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Bingham, "but he had tremendous ambition and the most immense vocabulary I ever heard."

Dr. Mason worked in Bingham's grocery store starting as a stock boy and eventually working his way up to store manager at the age of seventeen.

He didn't participate in athletics or a lot of other activities because when he wasn't in school learning about science, he was working. In addition to the grocery store, he worked in a laundromat repairing washers and dryers. On Sunday mornings, he would collect the car keys of the people in the neighborhood and wash cars until four or five in the afternoon.

He worked summers and vacations at Continental Assurance Company. In each of these situations, Dr. Mason was lucky enough to have people who took an interest in him and urged him to succeed.

"All of them were very instrumental in helping me to build my self-confidence in terms of how I was able to do things. And I guess that's why I feel such a strong sense of responsibility to do this for these kids. Otherwise, in the communities that they live, the only images they see are drug pushers, or gang members or people in between."

Dr. Mason knows he was fortunate to get out. "There's no question that it's tougher now. I could see the difference as I was leaving the schools, because I lived in a changing neighborhood, and I was right on the cutting edge of the change."

When he talks about death, about the terrible and ultimate finality of AIDS, the proverbial pin could drop and it would shatter the stillness of the room like a gun shot.

"There's a war out there for our kids," he says. "Particularly, in our community you've got to look at the fact that a black male only has a one-in-four chance of graduating from high school. So what happens to those others?"

The number one cause of death of people between 18 and 35 in the black community is homicide, Dr. Mason says, and hope is in very short supply. He describes a program that he has helped put together for good students in a local high school that congratulates them on their efforts and encourages them to continue.

Dr. Mason completed undergraduate work at Loyola, eventually decided to become a doctor, and attended the University of Illinois Abraham Lincoln School of Medicine.

After finding he loved surgery, Dr. Mason did some research and found that there were only five urologists on the south side where he wanted to set up his practice. Dr. Mason interviewed each of them at length to determine whether urology was a viable option. Convinced that it was, he finished his general surgery residency at the University of Illinois Metro Group Hospital in 1980, and then did specialty training in urology at the Michael Reese Hospital and Medical Center.

One of the physicians Dr. Mason interviewed about his decision to specialize in urology, Dr. Harvey J. Whitfield, was instrumental in his admission to the Michael Reese program. Soon, Dr. Mason worked with Dr. Whitfield, eventually taking over his practice. Dr. Whitfield died this past year, and his portrait hangs in Dr. Mason's Printer's Row waiting room.

"You know, it was like God always had a friend there for me," he says as he recollects those days when he was trying to get into college and through medical school. "Somebody who was like my guardian angel, so to speak. And those people were always there with the right words to get me through."

After the bell had rung signalling the end of the final AIDS class at Cregier, Mason asked one of the teachers to find the student who had walked out more than an hour before. Shortly, Mason could be seen outside the library talking to the student. A few minutes later, Mason came back into the room. He was smiling. He said he had apologized to the student for embarrassing him and that the student had apologized for walking out.

"Everything's cool," Mason said. ▲

Over one hundred Illinois schools and community groups have requested presentations by the ISMS AIDS speakers bureau. Speakers can volunteer to appear before elementary and junior high groups, as well as other adolescent and adult forums. The Society provides background material, a videotape and speech outline for speakers. Physicians who would be willing to participate are encouraged to contact the ISMS Department of Public Relations, 312-782-1654; 1-800-ISMS.

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PUBLIC HEALTH REPORT

by Judy Alsofrom

LYME DISEASE, thought to be confined to areas of the East Coast, is travelling westward.

During the 1980's, Illinois residents accounted for 29 cases of this tic-borne disease, an epidemic inflammatory disorder marked by a characteristic skin rash. Six cases were reported in Illinois in 1987 and 11 in 1988.

The malady was first recognized in 1975 from a cluster of cases centered in Old Lyme, Connecticut. It has since spread along the northeast corridor and to other points west, with clusters in Texas, Minnesota and Wisconsin.

It is not clear whether there has been increased recognition of the disease or increased exposure to it, according to spokespersons at the Illinois Department of Public Health (IDPH), but in May, 1988, Lyme disease was added to the list of reportable diseases in Illinois.

Six Illinois counties have been identified as outbreak areas for Lyme disease, carried either by the deer tic, or bear tics in Wisconsin. They are: Lake, McLean, Peoria, LaSalle, Grundy and Macon counties. In most of the Illinois cases, however, patients reported travel to other states, primarily Wisconsin, Michigan, Minnesota, and California.

Tests for Lyme disease include indirect fluorescent antibody (IFA) and enzyme-linked immunoabsorbent assay. If the physician identifies an erythema chronicum migrans, the characteristic skin rash, the state public health lab will do an IFA free of charge.

IDPH recommends that persons visiting heavily wooded areas use tic repellant and wear protective clothing. They should also check their body for tics and remove attached ones with a forceps or tissue, gently and firmly pulling the tic straight out without twisting. IDPH warns against burning or suffocating tics, which might cause them to transfer the causative agent.

Tetracycline is the treatment of choice for affected adults.

THE PUBLIC HEALTH department alerts physicians to a statewide outbreak of B-Victoria influenza, primarily in children and young adults, and issues a warning against using aspirin to treat children with influenza or influenza-like syndrome, because of the aspirin-Reye's syndrome link. ▲

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Mayoral hopefuls vow health dept. changes

POLITICS in Chicago is always interesting and often unpredictable. Few would have guessed six weeks ago that Republican hopeful Edward R. Vrdolyak's last minute write-in campaign would succeed in toppling Herbert R. Sohn, M.D., a board certified urologist who also holds a law degree. Dr. Sohn, an ISMS member who has long been active in local politics, had been endorsed by the local party leadership. But he was bested by a veteran city politician, whose highly organized last-minute write-in campaign gave him a 5% edge in the primary, and the Republican mantle in next month's general election.

Vrdolyak's office was unable to supply a health care agenda. But platforms provided by the Democratic candidate, State's Attorney Richard M. Daley, and the Harold T. Washington party candidate, Alderman Timothy Evans, echoed common themes.



Edward R. Vrdolyak



Herbert R. Sohn, M.D.



Richard M. Daley



Timothy Evans

Administration the first target

Both Daley and Evans would conduct a nationwide search to replace city health commissioner Lonnie Edwards, M.D., and conduct what Daley terms a "top to bottom audit" of the health department.

Each would attack the Chicago Health Department's administrative structure. Evans' plan calls for a comprehensive city-wide intergovernmental health care network of ambulatory clinics, coordinated referrals and affiliated private facilities. Daley would begin with a summit meeting of county, state and federal leaders designed "to establish a broadly representative action group charged with implementing a coordinated and streamlined health care program."

Infant mortality

Evans would seek to bring the Chicago infant mortality rate down to at least the 11.5 per 1000 statewide average within the next four years. He would accomplish this by tripling the number of skilled public health nurses and revitalizing community clinics, including school-based clinics for pregnant teens. Daley agrees with that, and also would call for an evaluation of the present infant mortality reduction plan to ensure integrated hospital, outpatient and community services.

Lead poisoning and other matters

While both Daley and Evans target lead poisoning of Chicago's children, Evans would approach it with education, public health screening and tenants' rights advocacy, while Daley would step up building inspection and law enforcement action against landlords. Both candidates call for a fresh look at the Chicago trauma network to ensure interagency cooperation at local, state and federal levels. Evans' platform also calls for expanded "accessible, voluntary, and confidential counseling sites," for AIDS patients, and caregiver support services. Evans would also expand the community clinic network with publicly funded, free-standing community health centers in the black and hispanic communities. ▲

Rockford Merger

(continued from page 1)

the hospital industry is no different from any other and that non-profit status doesn't exempt hospitals from antitrust rulings. In *Roanoke,* the court performed a similar analysis but reached a different conclusion. That decision suggests that a non-profit hospital should be accorded more latitude under antitrust than other industries."

Having won the Rockford case, Bloch applauded Judge Roszkowski's opinion as "totally consistent with legal precedent representing similar issues in the Hospital Corporation of America case." That 1986 Nashville, Tennessee case (*Federal Trade Commission* vs. *HCA*) was the leading precedent for both *Rockford* and *Roanoke.* However, because the Nashville case involved for-profit hospitals, the Justice Department was extremely interested in seeing how that precedent would be applied to nonprofit institutions.

Differing statutes

While the Justice Department sees the two cases as similar, Rob McCann, a partner at Epstein, Becker, and Green, the Washington, D.C. attorneys for the Roanoke hospitals, pointed to one clear difference. The two suits went to trial under different statutes—section one of the Sherman Act in *Roanoke* and section seven of the Clayton Act in *Rockford.* The Justice Department believed that, because these statutes address similar antitrust issues, the analysis of each case should reach the same conclusion, while McCann saw the two statutes as having differing impacts.

McCann described the status of the two Roanoke hospitals. "Roanoke Memorial is a large referral center in an ancient plant, where, in some circumstances it can barely juggle the patients that it has," he said. "Community Hospital of Roanoke is a relatively new facility that is basically empty." The logic of the merger was to consolidate and allow Roanoke Memorial to shift some of their clinical services to Community, thus alleviating the stress on its facility.

The Rockford hospitals were represented by the Chicago law firm Gardener, Carton, and Douglas. One of the attorneys who worked on the case described the hospitals as being of about the same size. Both are tertiary care facilities offering a full range of services, although these services do not in all cases overlap. "The primary reason for the merger as expressed by the hospitals," said the attorney, who asked not to be named, "was to develop a major tertiary care referral center and in doing so to combine certain programs and services so that there would be economy of scale within programs." The hospitals saw the proposed merger as resulting in better training programs. It would allow them to recruit and attract specialists, while consolidating existing programs and developing new ones.

The Rockford hospitals' attorney agreed with McCann as to the significance of the cases having gone to court under different statutes. The two attorneys also agreed that both cases were decided on the issues of geographic market, product market, and, most importantly, on evidence of the competitive impact of the mergers. The details of the cases and the conclusions drawn by the judges are now a matter of public record. In the end, Judge Turk in *Roanoke* allowed the merger while Judge Roszkowski in *Rockford* did not. The Justice Department has already taken steps toward appealing the *Roanoke* decision.

While appeal is also a possibility for the Rockford hospitals, Tom Myers, Director of Public Relations and Communications at Swedish-American, said that it would be premature to determine that appeal would be their next step. "The next step," he said, "is for us to meet with legal counsel to discuss our options." Dr. Henry expressed disappointment in the Rockford decision and added that the hospitals' attorneys are currently looking at some of the finer points of the case in order to determine the chances of winning on appeal.

"It seems to us," Dr. Henry said, "That collaboration and particularly merger and consolidation would have cut down some of the replication of services here and would have been good for the community. But obviously we didn't convince the judge."

Court considerations

Judge Roszkowski addressed this issue in his decision. "Certainly, view-

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ing the proposed merger from the perspective of a purely business decision, the merger makes sense. It would allow the new entity to eliminate certain duplicative services and equipment, with the attendant reduction in personnel and other costs. It would improve the capital position of the new entity, as opposed to the old entities, thus allowing for greater expenditures for equipment and possibly improving the ability of the new entity to buy in larger quantities, reducing some costs. It might also allow the new entity to improve its services to the extent that it might become a major medical center, providing tertiary care in a wider range of services and in a broader geographical area. These are but a few of the business advantages which may inure to the benefit of the defendants if the merger is allowed to proceed. Others may also come to mind. In an anti-trust context, however, it is *competition,* not the *competitors,* which the laws seek to protect."

That there is economic logic behind mergers and acquisitions cannot be denied. Edward Lawlor, assistant professor at the University of Chicago School of Social Service Administration, is an expert in health care policy. "What the courts have been concerned about," he said, "is the potential that if hospitals get together and create larger and larger organizations, their market power is going to grow and they're going to be able to collude and set prices. That is particularly a problem in a small area where there are few hospitals." In Lawlor's opinion, the Rockford merger of two out of three hospitals would leave little or no room for competition.

Recently, Lawlor pointed out, a new goal, apart from cutting the duplication of services, has added pressure to the economic drive toward merger. "There's a lot of concern among providers," he said, "That they put themselves together in a united front so that they can bid with the big payers for care in a competitive way." Faced with the need to negotiate with big HMOs, insurance companies, and the government, hospitals find that being affiliated in networks and bidding in groups puts them in a stronger bargaining position.

It is important to note that this merger goal is not viewed as desirable by the Justice Department. They brought suit in Rockford and Roanoke after concluding that in both instances the mergers would give the resulting entity more than 70% of the acute inpatient hospital care market, and that the merged firm could use market power to raise prices to discourage and resist competitive pressure by HMOs, PPOs, and third party payer groups that are trying to seek discounts and contain health care costs.

As a second common reason for merger, Lawlor listed the increasing need of hospitals to offer more diversified sets of services. "It doesn't make sense for individual hospitals to try to do that themselves," he said. "But many institutions have specialty services that make them very attractive to put together in a package." Third, affiliations allow hospitals to capture a mixed market. This works especially well when two hospitals located in different geographic areas of a city join forces. The recent affiliation between Chicago's Weiss Memorial Hospital and the University of Chicago Hospitals is a good example.

Aside from the legal concerns voiced by the Justice Department, socially aware observers of the affiliation phenomenon are concerned with what Lawlor calls segmentation. "The fear is that the well-off institutions will link themselves together," he said, "leaving a set of distressed institutions who are out of the loop." This touches on the troubling issue of hospital closings. Not long ago some non-profit systems were affiliating with hospitals in poor neighborhoods, but, according to Lawlor, this is no longer common. "There is some concern," he continued, "that the healthy are banding together and a whole other tier of the hospital system is being left out."

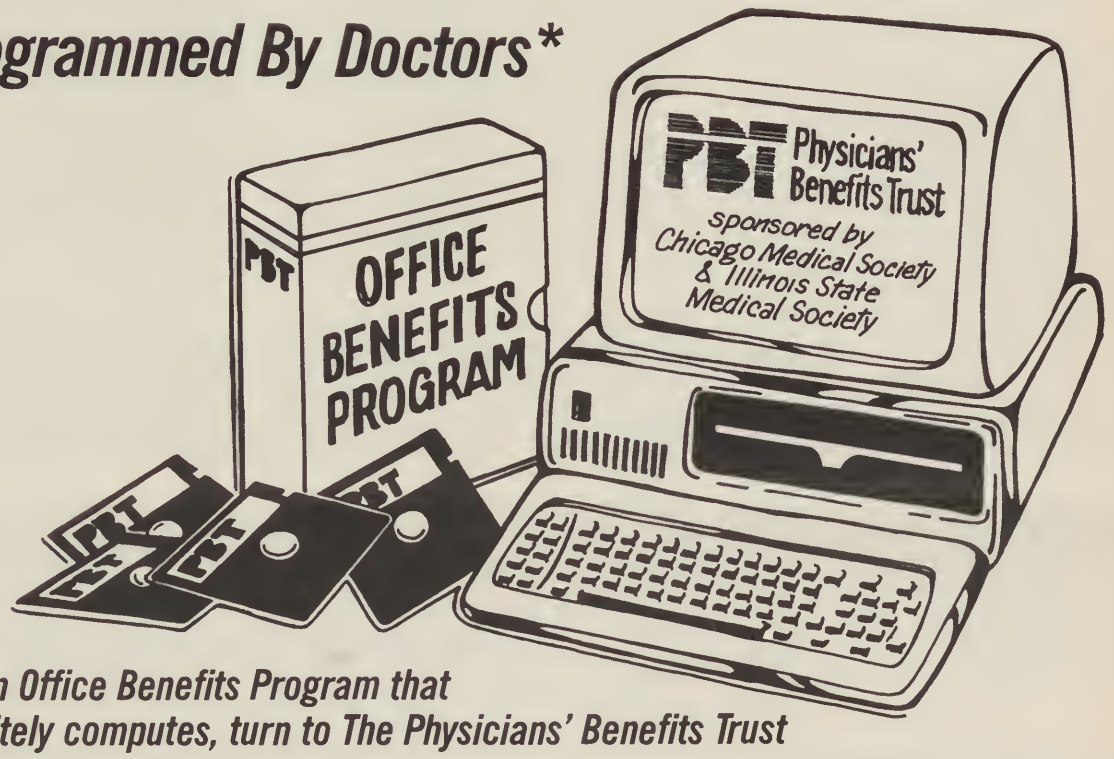
In Rockford, reactions to the judge's decision outside the two hospitals varied. Bernard Salafsky, Ph.D., director of the University of Illinois College of Medicine, Rockford, said that while some cited educational opportunities during the merger debate, those opportunities were never spelled out. "In my own mind," Dr. Salafsky said, "it is clear that had there been a merger it probably would have moved us closer sooner to becoming a tertiary referral center."

The University currently has affiliation agreements with both hospitals as well as Rockford's St. Anthony Medical Center. Dr. Salafsky stated that the merger would have brought the school closer to becoming a medical center. "But," he concluded, "from an educational point of view, the College of Medicine of Rockford will do just as well with or without the merger."

As for the Rockford hospitals themselves, despite the ruling of the court, they remain convinced that the consolidation of their two organizations is in the best interest of the community. Their next step will be to meet with their respective boards of directors to review the judge's decision, assess their options, and decide where to go from there.

A larger question will linger long after these suits are finally settled. How can the cost of health care in this country best be contained? Through competition among hospitals, or through mergers and affiliations that address economies of scale? ▲

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March 31, 1989

ILLINOIS STATE MEDICAL SOCIETY

Charting a Ready Defense . . . 7

Dissecting discipline

by Eileen Norris

BECAUSE MOST physicians practice good medicine and don't run afoul of the law, they might not concern themselves with the work of the Medical Disciplinary Board.

Yet the five physicians, one osteopath, one chiropractor and two nonvoting lay people appointed by the Governor to this state-regulated peer review group know that what they do—and how they do it—is important.

That's especially true in light of the new Medical Practice Act, which recently was rewritten to give the state a beefed-up investigative and legal staff, along with tougher, more enforceable sanctions that can be taken against unethical, illegal, incompetent or improper physician behavior.

Members of the Medical Disciplinary Board, (which itself is a statutory body of the Illinois Department of Professional Regulation) want their physician colleagues to know that the group works for the medical community and the public to ferret out those occasional "bad apple" doctors who give the profession a bad name.

The board also tries to give a second chance to those physicians who have temporarily gone astray and might need help getting themselves back on track.

Physician board members say that they can't help but see a complaint from the physician's point of view. Despite that—or perhaps because of it—doctors found to be flagrantly abusing the law, (by illegally dispensing drugs, for example) will not get much sympathy from this peer group.

"If you're not behaving yourself, we'll clobber the hell out of you," says

(continued on page 12)





Medical Disciplinary Board members (L to R) Biswamay Ray, M.D., Oak Brook, Otto Brosius, M.D., Decatur, and Virgil Wikoff, Champaign, along with the Board's six other members, make final decisions on cases which originate from complaints reviewed by IDPR medical coordinators Kenneth Eggen, M.D., Chicago (L), and Chauncey Maher, M.D., Springfield (R).

ANNUAL MEETING 1989

PROPOSALS on topics ranging from the use of abandoned rail lines for recreation to adequate health care funding for the state's uninsured and underinsured await consideration of Illinois State Medical Society (ISMS) members attending the 1989 annual meeting which begins Friday, April 7 at the Westin O'Hare Hotel in Rosemont.

Interested members will have an opportunity to observe, debate and testify at reference committee hearings scheduled to convene Friday afternoon at 2 p.m. (Reference Committee A will convene at 1:30 p.m. for a special presentation on the ISMS 1988 audited financial statement.)

Reference committees composed of experienced delegates evaluate and summarize points made in debate on each resolution. They then draft recommendations for House of Delegates action the next day. The reference committee system enables the Society to give fair hearing to the 56 resolutions proposed to amend the Society's policies.

Reference Committee A

The Resident Physicians Section in Resolution 47 asks the ISMS to urge Illinois residency programs to provide health, life and disability insurance to their housestaff. The Hospital Medical Staff Section calls for community, hospital medical staff, and county society involvement in decisions to close a hospital in Reso-

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The Medical Environment

A periodic observation on trends in the context of modern medical practice and the challenges they present.

On the defensive

When a physician is sued, fear becomes part of the cost of doing business

by Sean Kennan

"BOK-SIE?" She'd waited three days to utter those two syllables. Bloodied at the shoulder, unwashed, underfed, and reeking of infection, the Vietnamese woman had been caught in the middle of a Viet Cong rocket attack when shell fragments tore open her upper arm. With several others she walked for two and a half days from the scene of the incident to a small town outside of Hue, in what was then the Republic of South Vietnam.

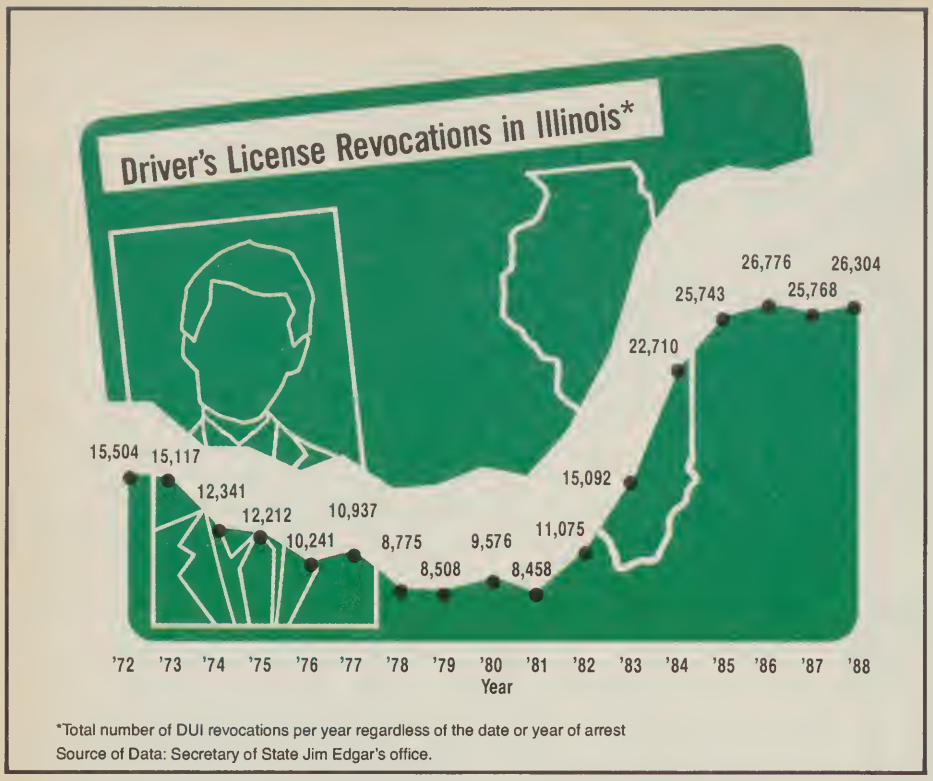
There, looking into the round eyes and caucasian face of the man in green fatigues, she sees his affirmative nod and manages a smile. She

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*Total number of DUI revocations per year regardless of the date or year of arrest
Source of Data: Secretary of State Jim Edgar's office.

Drunken driving: a dangerous symptom

by Laura Bianchi

IN ILLINOIS, driving under the influence of alcohol or other drugs (DUI) is treated as more then just a crime to punish. It is considered a dangerous symptom of a disease requiring treatment.

In light of that, the state three years ago began requiring that everyone arrested for drunken driving submit to a drug and alcohol evaluation before sentencing to determine the nature and extent of their use and whether that relates to the drunken driving arrest.

The courts then take that information into consideration during sentencing or in awarding driving privileges.

"The idea is to identify an alcohol and drug problem and get the person into treatment if they need it," said Norma Seibert, supervisor of the DUI Unit with the Department of Alcohol and Substance Abuse. "This is not a pass. Treatment is considered part of the sanction, it is not in lieu of a sanction," such as losing driving privileges, serving a jail term or paying a fine.

Since January 1986 when the law went into effect, 260 evaluation programs have been established statewide, along with 195 remedial education programs. All evaluators are licensed and monitored by the Illinois Department of Alcohol and Substance Abuse (DASA), and they handle about 60,000 evaluations each year.

Here's how it works:

When a person is arrested for drunken driving, he is advised by his attorney or a judge to submit to an alcohol and drug use evaluation. The courts will not proceed with sentencing or award judicial driving privileges until the evaluation is completed.

At the DUI evaluation center, the offender spends roughly three hours filling out a questionnaire and responding to questions during an oral interview with a case worker. The information gleaned from that session is used to classify the offender at one of three levels ranging from nonproblematic usage to problematic/dependent. The case worker then makes a recommendation to the courts for intervention, ranging from a 10-hour remedial education program to inpatient treatment.

The average cost of an evaluation is $80, paid by the defendant.

"The courts are under no obligation to follow any of the recommendations," Seibert said. "It is still up to the discretion of the judge. But we would very much like to see mandatory treatment for those determined to need it. That's the only way we're going to make a dent in this population."

Most of the DUI evaluation programs are located in drug and alcohol treatment centers or are operated by psychologists or social workers in private practice. Those who administer evaluations must meet certain minimum requirements established by DASA, which also maintains a directory of all licensed programs and conducts routine inspections of them.

"This is a very important tool in our efforts to make the highways safe," said Secretary of State Jim Edgar, who created the evaluation system after he entered office. "When I first came into office in 1981, I didn't think it made sense to take drunk drivers off the road for a while and then put them back on if they had a serious drinking problem. We have to encourage rehabilitation, so when they go back on the road they have the problem in control."

Still, Edgar acknowledged that steering drunk drivers into treatment is easier said than done.

"There is no magic formula, no easy way to evaluate" alcohol and drug use in those arrested, he said. Because of that, evaluations are inconsistent, and some evaluators are more lenient than others.

Recently the state doubled the reinstatement fees for drunken drivers and a portion of that increase will go to DASA for monitoring evaluators.

Despite some encouraging figures on drunken driving for Illinois, it is difficult to assess the specific impact of the DUI evaluations because they are just part of a larger, statewide campaign against drunken driving, Edgar said.

"We have been effective in reaching the nonproblematic user through public education campaigns and deterrence efforts by the police and the Secretary of State," Seibert said.

Beyond that, Illinois has achieved a 20 percent decline in alcohol-related fatalities during the last four years.

"The bad news is that there is a very dangerous group of drivers on the road that have drug and alcohol problems, and who will continue to drive until they get into treatment," Seibert said. "They are sick and they need help. Our only hope is to get them off the road before they kill themselves or somebody else." ▲

EDITOR'S NOTE: For the location of DUI evaluation programs in a specific area, contact DASA at 312/917-3229 or 217/782-6258.

History of DUI laws

During the past six years, the Illinois DUI law has been revised and simplified, making it one of the nation's most effective, according to Secretary of State Jim Edgar's office.

One of the most significant changes was the passage of the summary suspension law, which allows the Secretary of State's office to revoke driving privileges without taking the offender to court.

Specifically, first-time DUI offenders automatically lose driving privileges for three months if their blood alcohol level measures .10 or greater, or for six months if they refuse to submit to the chemical test.

On subsequent offenses, a driver will lose his license for 12 months for either of those offenses.

Since that law went into effect, more than three times the number of offenders have lost their licenses in the year of arrest, including 42, 749 during 1987. In 1985, that figure was 13,047.

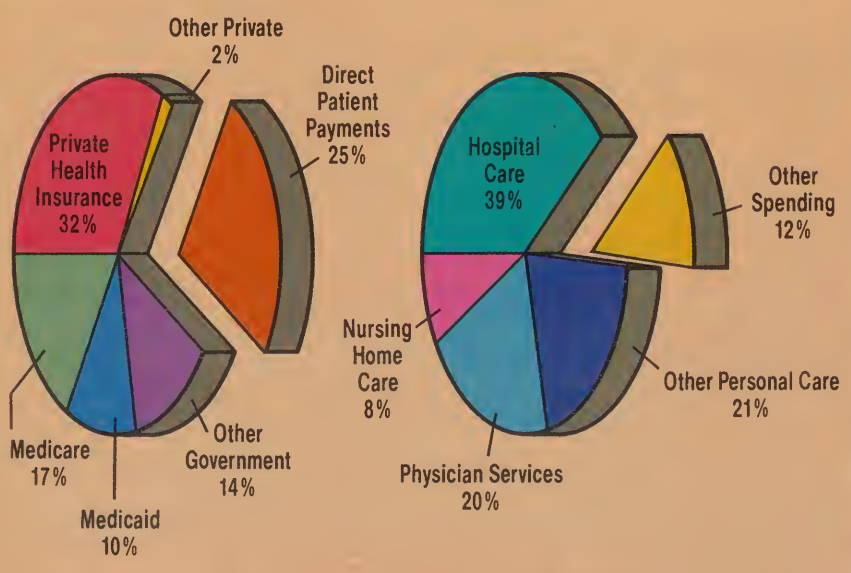
In addition to the summary suspension, those arrested for drunken driving are subject to court-ordered sanctions as follows:

- ☐ First DUI conviction results in a minimum one-year loss of full driving privileges, possible imprisonment for up to one year and a maximum fine of $1,000.
- ☐ The second DUI conviction within 20 years results in a minimum three-year loss of full driving privileges. For a second conviction in five years, the penalty is a mandatory 48 hours in jail or 10 days community service. The second conviction also can result in imprisonment for up to one year and/or a maximum fine of $1,000.
- ☐ A third DUI conviction is considered a Class 4 felony carrying a maximum six-year loss of full driving privileges, possible imprisonment for up to three years and/or maximum fine of $10,000. ▲

Physician Facts

The Nation's Health Dollar in 1987

Where It Came From . . . *. . . And Where It Went*



Source of Data: Health Care Financing Administration

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New stumbling blocks greet UI/Reese affiliation plan

by Kevin O'Brien

PRESSURE FROM elected officials and continuing opposition from members of the University of Illinois Hospital medical staff have delayed approval of a proposed affiliation between the university medical school and Michael Reese Hospital and Medical Center. Instead, the university Board of Trustees voted at their March 9 meeting to reaffirm support "in principle" and defer action for another month.

It is not clear whether the trustees were greatly influenced by a last minute, hand-delivered letter from Rush-Presbyterian-St. Luke's Medical Center Chairman Edgar D. Jannotta, seeking to renew previously abandoned affiliation talks. It is clear the the Rush initiative, legislative hearings in Chicago, and trustee hearings in Champaign have further complicated an already fluid situation.

Essential strategy

The proposed affiliation agreement would make Reese the university's primary teaching hospital and calls for the construction of a $40 million to $50 million ambulatory care center on the Reese campus that the university would lease on a long-term basis. It does not specify the amount the university would pay to lease the facility, saying only that this would depend on how much space the university uses, and how much it will cost Reese to construct and staff the facility.

The Reese agreement is part of a package under which the university would also affiliate with Cook County Hospital with a "use agreement" allowing the county to operate the university's eight-year-old 500-bed hospital. The county hopes that use of the state-of-the-art hospital will combine with use of the shuttered Provident Hospital on the city's south side to preclude the need to construct a new county hospital to replace the current aging facility.

Opponents claim that the Reese agreement gives the hospital too much control over academic appointments. They further contend that by "closing" the university hospital, the university is abandoning its commitment to provide health care to an ever-increasing medically indigent population.

University officials counter that the university will retain necessary control over all academic programs, and that statements contending that the university hospital is "closing" distort the facts. They maintain that the hospital will not be closed, but merely operated by another entity. In the process, they say, the number of beds available to indigent patients will increase, and the Cook County Hospital arrangement will strengthen the quality of medical care provided poor patients.

Medical staff opposition

Members of the university hospital's medical staff have vocally opposed the affiliation from the outset, and have found some support both within the university and in the communities served by the so-called West Side Medical Center District.

During the past two months, the medical staff has held a series of "open" meetings to plan strategy for mobilizing academic, community and media support. These meetings have resulted in a vote of "no confidence" in the university administration, as well as the "floating" of an idea that the university affiliate with Rush.

Further, in accordance with university statutes, more than 100 faculty members recently presented a petition asking for a "special" meeting of the College of Medicine faculty to debate a resolution calling for the resignation of Dean Phillip M. Forman, M.D., generally regarded as one of the architects of the affiliation plan. The meeting has been scheduled for April 5.

Indigent care, academic control at issue

It was this carefully orchestrated opposition that prompted State Sen. Margaret Smith (D-Chicago) to convene a hearing in Chicago of the Public Health, Welfare and Corrections Committee two days before the March 9 trustee meeting.

Approximately 20 of the scheduled 26 witnesses at the senate hearing testified in opposition to the proposed affiliations. At the end of the day-long hearing, the senators issued a statement calling on the university trustees to defer final approval until an impact study of the proposed affiliations could be completed. University president Stanley O. Ikenberry has since asked the Illinois Department of Public Health to complete such a study in time for the April trustees meeting.

The committee requested an opinion from the Illinois Attorney General regarding the legality of agreements between public universities and private hospitals without statutory approval. And they asked that the involved institutions provide written answers to 23 additional questions regarding the affiliations.

Two days later in Urbana-Champaign, the board conducted its own originally scheduled two-hour hearing that instead stretched on for six. While many of the same witnesses who testified in Chicago appeared before the trustees, the board also heard from several supporters of the plan.

(continued on page 9)

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REPORT FOR *Illinois Physicians*

NEW BLUE CROSS BUSINESS

Blue Cross and Blue Shield of Illinois (BCBSI) is pleased to announce the following new employer groups which became effective with BCBSI on January 1, 1989.

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MEDICAL SERVICES ADVISORY (MSA) PROGRAM

The BCBSI Medical Services Advisory (MSA) Program, a utilization management program including preadmission certification, is a component of the BCBSI PPO product and therefore applies to all the new PPO groups listed above.

Traditional groups also have the option of participating in the BCBSI MSA. The following groups have added the MSA to their benefit program effective January 1, 1989:

ITW, Signode
Group Number: 022141

Northwestern Hospital
Group Number: 059087

The Medical Services Advisory Program (MSA) and the Hospital Preferred Provider Option (PPO) Program were featured in the "Blue Cross and Blue Shield Report for Illinois Physicians" dated February 3, 1989 (MSA) and March 3, 1989 (PPO) respectively.

The BCBSI members of the PPO and MSA groups listed above carry standard BCBSI cards. However, R. R. Donnelley and Spiegel group cards display the name of the group and R. R. Donnelley's cards are plastic.

(This report is a service to the physicians of Illinois)
3/31/89

Editorials

Medical discipline: a two-way street

The story on medical discipline in this issue reinforces the fact that increased attention is being given to professional discipline—by professionals themselves.

Illinois doctors took the lead in generating many of the improvements contained in the revised Medical Practice Act enacted last year. Through the Governor's Task Force on Medical Discipline, their work has paid off. The new disciplinary law embodies many improvements: strengthened and expanded grounds for medical discipline; new penalties for doctors with inappropriate business practices; the placement of affirmative responsibility on physicians to report disciplinary actions taken against them; stricter educational requirements for prospective physicians; and several others.

Effective discipline is a two-way street. The state's authority to grant licensure carries a responsibility to interpret and administer the law fairly, without arbitrary, capricious or smothering application. In fact, new safeguards now protect physician offices from arbitrary state inspection or access to medical records without subpoena. In turn, physicians accept the responsibility to act as professionals with the highest standards. We also must accept the obligation, under strict confidentiality protection, to report wrongdoing by fellow practitioners. The principles of medical ethics and responsibility to the public demand that physicians bring bad medical practice to the attention of the authorities.

An effective system of medical discipline is an important component of quality care. Commitment to professional standards is equally essential to our professional integrity.

ISMS Annual Meeting: an educated forum

As delegates gather for the 1989 Annual Meeting of the Illinois State Medical Society, they will find many of the major challenges facing medicine today echoed in the resolutions before them for debate. The delegates will wrestle with a formidable array of substantive, stubborn issues reflecting Illinois' continuing health care problems. Among them are public health concerns such as tobacco use, AIDS and alcohol. Delegates will also debate important legal and economic issues pertaining to alternative delivery systems, professional liability, third party payers, and access to care. Questions of medical ethics and physicians' prerogatives will also be featured.

Clearly, there are no easy solutions. But the annual meeting is a meaningful forum that can produce far-reaching benefits for physicians and their patients. Our delegates come together from every corner of Illinois. They represent diverse viewpoints and priorities, tempered by intelligence, experience and insight. We are confident that the delegates' decisions will shape policy that affirms ISMS as a leader in formulating and achieving effective programs for the future of health care in Illinois. ▲

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Guest Editorial

Dependent on the charity of strangers



Stephen H. Miles, M.D.

by Steven H. Miles, M.D.

FOUR YEARS ago, I was a guest lecturer on geriatric medicine in a chronic care hospital. After my talk, the medical director proudly asked if I would like to see the "feeding ward." He took me down a long corridor to two wards, each with 18 beds. On each bed, a still lump was covered by a blanket. These patients were in the final stages of devastating progressive brain diseases. They no longer spoke, or moved, or recognized their attendants. Pumps stood at the head of each bed from which plastic tubes carried a creamy liquid under the blankets. A single nurse sat at a desk in the corner. The wards were quiet.

"Were these patients ever involved in discussions about this type of treatment?" I asked. "No," he said, "most were quite impaired by the time they stopped eating and the tubes were inserted." "Are their families involved in this care?" "No," he said, "families get discouraged by this kind of situation and stop coming after a while." "Is there ever any review of whether this therapy should be continued?" "Oh no, that would be unthinkable!"

The Illinois Supreme Court is now hearing a story which might have come from that ward. Four years ago, Sidney Greenspan was an elderly working man. A stroke put him in a coma. He is unresponsive, recognizes nothing, is contracted in a ball, and will stay that way. He is sustained by tube feedings. His wife and family maintain that he specifically and repeatedly said that he would not want to be sustained in this manner. They want the feeding tube withdrawn.

At its simplest level, this is a story of medical technology whose power and availability demands our discerning discretion. Death now occurs under medical care. Eighty-five percent of more than 2 million deaths each year occur in hospitals and nursing homes. The discretionary use of medical care is inextricably connected to the hour of death. Machines, drugs and electricity, which are healing in other circumstances, extract the last bit of life from only a minority of bodies. Half of elderly dialysis patients succumb to kidney disease—not neglect, murder or suicide—after the decision is made to stop unwanted artificial kidney treatments.

Perhaps 70 percent of all deaths are accompanied by decisions to withhold or withdraw life-prolonging treatment. Courts, professional bodies and public opinion have accommodated the view that medical technology—from respirators to the deceptively simple pumps, tubing and solutions of nutritional support—is a matter of choice and difficult moral responsibility.

Medical technology is a way we care. But it is the caregiving, not the technology, that we honor. The automated silence of the feeding ward where families and patient's voices may not be spoken is not a human caregiving. Where dialogue is not possible, symbols of care replace its substance. Some of the comatose, without loving families, depend entirely on the charity of strangers. They are vulnerable because we, as strangers, are inclined to manipulate technology to serve our public moods. Fear of the disabled or of "scarce medical resources" can make neglect a virtue. An ascetic purity can affirm technically supported biological life no matter what its burden. Sidney Greenspan is not vulnerable in this sense. His family has not abandoned him or been driven away by the perpetual motion of medical machines.

Ultimately, the Greenspan case is about the public conduct of private life. It is an unhappy circumstance that his death occurs in a public institution. At home, sips of broth tendered by loving caregivers to the limits of his thirst and ability to swallow would fulfill the duty to care. And, having lived fully and been loved fully, he would have died. In public institutions, like nursing homes, those sips are measured in milliliters.

How can we know how to care for him? The custodians of public order—judges, professional advocates, nutrition technologists—with their clumsy symbols of principles, regulations and physiologic calculation, are inadequate to this task. In this instance, it helps to recall that the word "care" comes from the word "lament." We need a public ethic of "lament," or moral perception intimately knowing of mortal life as Mr. Greenspan lived it and spoke of it by word and deed to those he chose to share it with. To accommodate this ethic, we need a private space within the public life of institutions for loving families like the Greenspans who can discern—and will assume—their tragic responsibility with their memories and in their loss. ▲

Steven H. Miles, M.D., is associate director of the Center for Clinical Medical Ethics at the University of Chicago. He testified on behalf of the Greenspan family.

Hospital Medical Staff Section elects new officers

DELEGATES to the fourth annual meeting of the Illinois State Medical Society's Hospital Medical Staff Section (ISMS HMSS) elected its 1989 Governing Council on February 18.

Elected ISMS HMSS chairman was Silvana Y. Menendez, M.D., a Belleville psychiatrist. Dr. Menendez, who represents Belleville Memorial Hospital, has been a Council member since the inception of the Governing Council in 1985. She succeeds Joseph L. Murphy, M.D., an internal medicine specialist from St. Joseph's Hospital in Chicago, who was elected an at-large member of the Section. Dr. Murphy, an AMA HMSS representative since 1983, is seeking a spot on that national Governing Council.

Other Council members elected were: Dennis M. Brown, M.D., Schaumburg, representing Alexian Brothers Hospital, vice chairman; Geoffrey A. Bland, M.D., Springfield, representing Memorial Medical Center, delegate; Jaroslav F. Neskodny, M.D., Berwyn, representing MacNeal Memorial Hospital, alternate delegate; William E. Kobler, M.D., Rockford, representing St. Anthony Medical Center, at-large member.

The Section proposed changes in the Constitution and Bylaws to add two at-large members. Designed to increase participation in the Section, this proposal will be submitted for approval to the ISMS Board of Trustees in April.

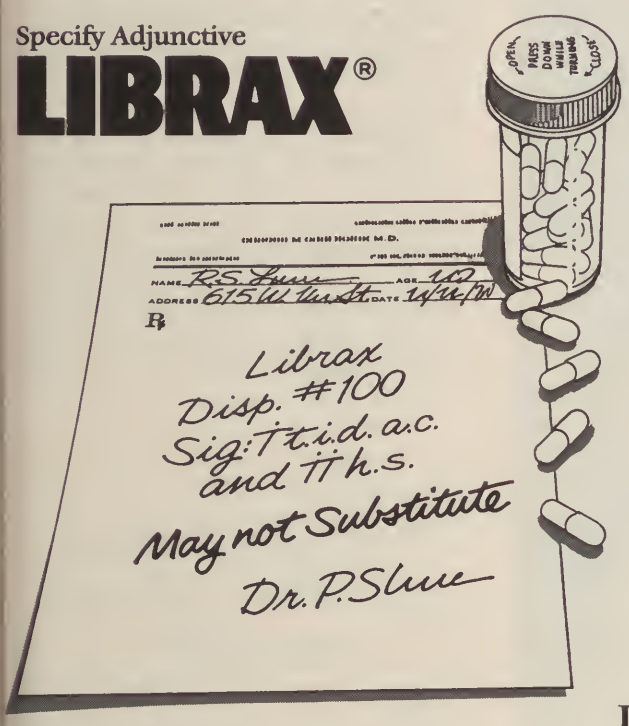
ISMS HMSS Governing Council members whose terms are up for election in 1990 include: treasurer, Thomas C. Malvar, M.D., Chicago, representing St. Mary of Nazareth Hospital; secretary, Charles R. Frazer, M.D. of East St. Louis representing St. Mary's Hospital; at large members John F. Schneider, M.D., Chicago, representing the University of Chicago Hospitals and Clinics and Albino T. Bismonte, M.D., Gurnee, representing Victory Memorial Hospital in Waukegan.

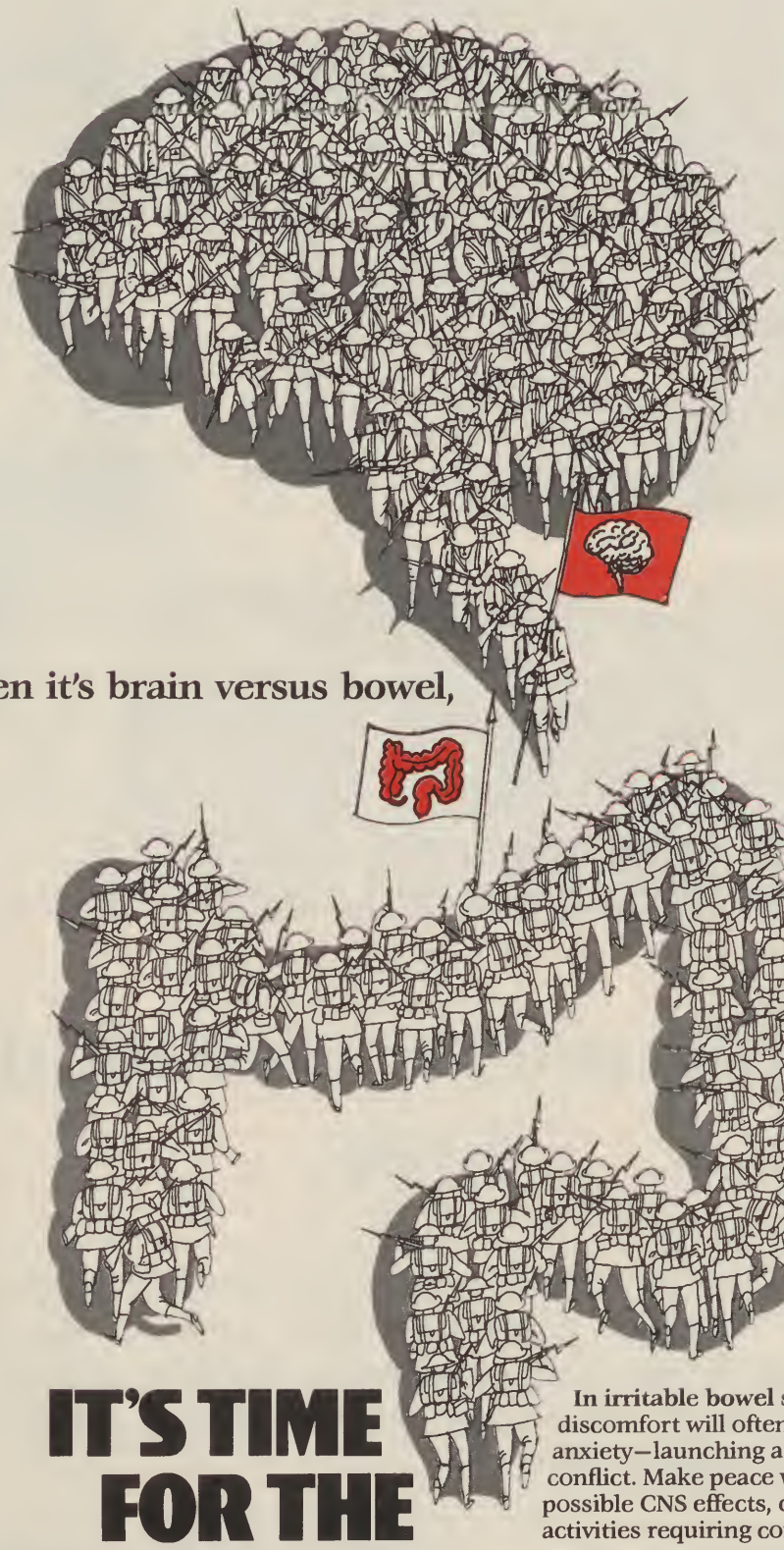
The 1989 election will be held at the Chicago Marriott on Saturday, June 17.

ISMS Board of Trustees Chairman Harold L. Jensen, M.D. speaking on the topic "Peer Review in the Hospital Setting," urged delegates to consider peer review and quality assurance as a process for ensuring continuous improvement in quality health care.

ISMS General Counsel Saul J. Morse, J.D., reviewed recent changes in the federal Health Care Quality Improvement Act as applied to hospital credentialing and quality assurance. John T. Kelly, M.D., AMA director of the Office of Quality Assurance described the AMA's quality assurance programs and AMA HMSS Governing Council member at-large Robert J. Weierman, M.D., closed the morning session with an update on AMA HMSS priorities. ▲

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Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Evangelical, ISMIE to Evaluate Physician Group Coverage

THE ILLINOIS STATE Medical Inter-Insurance Exchange (ISMIE) and Evangelical Hospital Systems, (EHS) Oak Brook, have announced that they are evaluating a joint program that will enhance the high standard of patient care at EHS institutions and reduce professional liability costs for EHS-participating physicians and EHS hospitals. ISMIE, created by the Illinois State Medical Society in 1976, is the state's largest physician medical malpractice insurer, and is owned and operated by physicians. The EHS hospitals are: Christ Hospital and Medical Center in Oak Lawn; Good Shepherd Hospital in Barrington; Good Samaritan Hospital in Downers Grove; and Bethany and South Chicago Community Hospitals, both in Chicago.

"This is the first joint ISMIE-hospital program," said Fred Z. White, M.D., chairman of the ISMIE Board of Governors, "and we are proceeding carefully and cautiously so that our objective of insuring physicians remains the primary objective. ISMIE strongly believes that physician policyholders in EHS hospitals will be well served by this program, which will allow both ISMIE policyholders and EHS hospitals to work together for early identification and cooperative defense of claims. There is also a joint risk management effort planned. In addition, we will be insuring ISMIE participating physicians at EHS hospitals on a group policy basis, and the group policy allows for future premium reductions as a result of good experience."

"Our primary reason for working with ISMIE on this program is to enhance a high standard of patient care in our hospitals," said William M. Wheeler, vice president of finance and treasurer of EHS. "We believe that with a joint claims-handling program, and especially a joint risk management program, we can go about the business of providing high quality patient care, while allowing the insurance professionals to be concerned with claims management.

Dr. White said that the program would not alter operating procedures at ISMIE. "ISMIE policyholders at EHS hospitals will have to meet ISMIE's underwriting guidelines in order to be insured, as well as be members of the Illinois State Medical Society," said Dr. White. "We will assign a professional liability analyst to work closely with EHS claims personnel, and our underwriting department may have a specific underwriter assigned to ISMIE policyholders at EHS hospitals. In addition, our risk management staff will be working closely with EHS risk managers. But there will be no special treatment of ISMIE policyholders at EHS hospitals that will in any way adversely affect the risks to other ISMIE policyholders, or the premiums of other ISMIE policyholders. ISMIE policyholders at EHS hospitals will retain all the rights and privileges of any other ISMIE policyholder, such as participation in the decision to settle or defend a claim and the right of appeal of most claims and underwriting decisions."

"ISMIE will *not* be insuring the hospitals; it will be insuring the ISMIE policyholders at the hospitals and will be cooperating with EHS in joint claims and risk management programs," said Dr. White. While the program has been in the developmental stages for several months, the actual group coverage program is expected to begin July 1, 1989. ▲

"ISMIE policyholders at EHS hospitals will have to meet ISMIE's underwriting guidelines in order to be insured, as well as be members of the Illinois State Medical Society"



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Solid OB care records chart a ready defense

by Kathleen Furore

RECORD KEEPING.

The phrase may keynote busywork to many physicians, but charting has taken on new significance in the modern professional liability climate. And obstetricians and family practitioners who deliver babies are among those whose insurance premiums for professional liability and required insurance coverage have increased.

Fred Z. White, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange (ISMIE), dealt with this issue in the Exchange booklet "Managing Your Risk."

"The threat of malpractice litigation has become an inescapable reality for all of us who practice medicine," he wrote. "But . . . there are things we can do about it. And one of the most fundamental is to implement effective risk reduction techniques."

One of those techniques is record keeping—a practice which not only functions as an effective risk management tool but also (and *most* importantly) provides a systematic approach to quality prenatal care for the mother and her unborn child.

ISMIE statistics support the popular assumption that obstetrics is a high risk specialty. OBGYN specialists rank first for claim severity as well as total number of claims. They are second only to orthopedic surgeons in number of claims per physician. This is consistent with the national experience: a 1987 study conducted by the American College of Obstetricians and Gynecologists (ACOG) found that some seven out of ten OBGYNs have been sued at some time during their careers and that more than 50% of claims against them are for obstetric cases. Insurance costs have soared in tandem: ISMIE 1988-89 policy year premiums for OBGYN ranged from $28,000 in rural Illinois to $51,000 in the Chicago metropolitan area for third year claims-made coverage.

All of this underscores the extent of the continuing liability crunch—and its implications for patient care.

Says ACOG's Associate Director of Liability Kenneth V. Heland, "These factors have prompted 12-13% of practicing OBGYNs to relinquish the obstetrics part of their practice, particularly that portion dedicated to high-risk care . . . and this trend is contributing to an access to care problem."

Just what can be done to relieve, if not resolve, this critical situation? Most experts agree that prenatal record keeping—done on a timely, accurate and consistent basis—is not only the most logical but also has the most expedient place to begin. The ISMIE risk management committee has recognized that fact and responded with a questionnaire for policyholders involved in prenatal care. The survey is designed to assess obstetric record keeping methods and facilitate CME.

Whether you are a practicing OBGYN or a family practitioner who delivers babies, it is essential to utilize a comprehensive prenatal record keeping form which tracks a patient's pregnancy from her first visit through her delivery. The first motivation of course, is quality care. The second is liability: no matter how thorough and professional the medical care you provide, it is the *record* of that care that often is on trial in malpractice suits.



LeRoy Sprang, M.D.

LeRoy Sprang, M.D., an OBGYN who serves on ISMIE's recently-formed risk management committee, identified two commonly used, reliable systems for physicians seeking a prenatal form: The Hollister Maternal/Newborn Record System© and the Advanced Medical Systems, Inc.'s "Prenatal Care—A Systems Approach."©

Although different by design, the Hollister and Advanced Medical Systems, Inc.'s prenatal forms *do* possess common elements: both begin with a summary sheet to detail the patient's health history; both use a prenatal flow chart to document progress per visit; and both have color-coded areas to alert the physician to existing or potential risks. All of these elements are crucial, notes Dr. Sprang, because ". . . the more risk factors you identify and the more effective your method of tracking them, the better able you are to provide sound medical care."

On the green and white Hollister form, developed more than a decade ago under the auspices of ACOG, that tracking takes place on a series of four standard-sized carbon-ready pages. Sections request the patient's age, race, ethnicity, and medical and pregnancy history. A "preexisting risk guide," allows doctors to check off conditions that classify a pregnancy and its outcome as a risk or high risk. There are areas to document her health since onset of most recent menses, and results of the initial exam, with green boxes where any abnormal findings can be noted. A prenatal flow record lists the physical condition of the mother and baby at each visit, and a risk factor assessment guide provides check-offs to record discussions concerning amniocentesis and types of delivery.

Similar information is requested on the Advanced Medical Systems form, developed over eight years ago by Arnold Greensher, M.D., of Colorado and Howard Roemer, M.D., of Oklahoma. This method of record keeping (when used in its entirety) involves not only a prenatal data base questionnaire and a pink, green and yellow-coded ambulatory prenatal flow sheet which monitors the entire pregnancy, but also a prenatal care manual, patient education handouts and a quarterly periodic update. An audiovisual staff training program comes with the package. The Colorado Physicians Insurance Company (COPIC) has recommended the Greensher system and purchased it for all of the family physicians and obstetricians it has insured since 1986. The system is credited, in part, with a reduction in COPIC's malpractice insurance rates for its doctors who deliver babies.

There are, of course, both positive and negative aspects to each of these standard forms. And while both are acceptable in Dr. Sprang's eyes, he does have some constructive criticism to offer.

"The Hollister form *is* less time-consuming and easier to use than Greensher's system," he comments. "But it is not as complete." Lacking, for example, are the patient education topics that are covered so thoroughly on the Advanced Medical Systems form.

The comprehensive quality of the Greensher system, conversely, is also one of its drawbacks. As Dr. Sprang explains, "Greensher's form *is* the most complete, but it is very complex . . . there is almost *too* much involved." He also notes that information about race and ethnicity never is requested, even though that information is required to determine the need for certain genetic testing (for diseases including Tay Sachs and sickle cell anemia).

Although no prenatal record keeping system is perfect, the need for one that is complete yet easy to follow is essential for every physician involved in obstetrical care. Consequently, many doctors create their own forms, combining the most crucial elements of the standard forms with information that will satisfy their own and their staff's needs.

Pedro Poma, M.D., of Melrose Park, is one of those doctors.

Realizing that "what is not in the record does not exist," the obstetrician and gynecologist developed what he considers a simplified system using information from a variety of record keeping forms. For him, it has provided a comfort and a familiarity with the system that might have been lacking had he chosen a pre-designed prenatal form.

Dr. Poma has included all of the information so necessary for top-quality obstetrical care: a patient profile, a health history, a physical examination report and a complete problem list. He has even added a follow-up form to track the results of tests ordered.

"It is important to develop a road map for the entire pregnancy," Dr. Poma explains. "And you must always identify the risks, then use them as neon signs to alert you to problems that might occur along the way." Some of those "road signs," he notes, may include a negative Rh factor; hypertension; diabetes; or age and heredity factors which could affect the pregnancy's outcome.

Clear, consistent patient records have always been a mark of quality patient care. More recently, the professional liability climate has raised the profile of record keeping systems in defense of medical malpractice suits. As Drs. Poma and Sprang concur, timely, accurate and consistent documentation of pregnancy is essential to a quality health care environment for mother and child, and an effective risk management tool should a problem involving litigation arise. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *I have a policy with the Exchange to cover my moonlighting activities while in a residency/fellowship program. I intend to complete the program this summer; how will this affect my policy?*

A: Your policy was written specifically to cover moonlighting activities while in a residency or fellowship program. Those who wish to continue coverage with the Exchange after residency/fellowship, must furnish information regarding new activities. We must receive this information by April 15, 1989, in order to renew the policy effective July 1, 1989. You may have already received a questionnaire requesting such information.

Q: *Our group has recently received a questionnaire about our medical activities. How important is it to respond and when is it due?*

A: Just as with the Quarterly Underwriting Questionnaire (QUQ) for individuals, the group QUQ must be completed and returned to the Exchange to ensure renewal of your policy on July first. Questions about medical activities of the group, contracts with any health care facility, HMO affiliations, and ownership of clinics or laboratories are included. Also required is an update of the shareholder/partner and employee roster. The questionnaire is due within 30 days of receipt. If it is not received within the allotted time, a final request is sent. Failure to return the final request questionnaire results in non-renewal of the policy effective July 1, 1989.

Q: *I am completing my residency/fellowship program this summer. How long will it take to process my application to insure me for my new practice?*

A: Summer is normally a busy time for ISMIE. Consequently, the processing of applications may take a little longer than during other times of the year. Typical processing time during this period is four to six weeks, provided applications are complete. All questions must be answered in full, and applications must be signed by the physician to be insured. Any and all applicable claims information must be provided, including a claim experience verification letter from the physician's previous carrier for the last 10 years of practice. Adherence to these suggestions should help ensure timely processing. ▲

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—The patient, a 29-year-old male, entered a hospital emergency room late one afternoon after falling in the street. He had briefly lost consciousness, presumably after striking his head. He had multiple abrasions, including contusions around both eyes.

Subsequent diagnoses—An initial examination by an emergency room physician showed no neurological deficit. The patient was found to be intoxicated with a blood alcohol level of .36. About four hours later, a second emergency room physician examined the patient and diagnosed neurological deficit. A neurosurgeon called in to consult diagnosed concussion but no lateralized findings. Ten days later, a neurosurgeon at another hospital diagnosed a large intracerebral hematoma.

The case in brief—When the patient first presented at the emergency room, his speech was slurred, but this was attributed to his intoxication. Skull x-rays proved negative. By early evening, however, a second emergency room physician examined the patient. Noting left-sided facial weakness and deviation of the tongue to the left, he concluded that there was neurological deficit.

At this point, a neurosurgeon was contacted. He approved admission of the patient to the intensive care unit for neurological observation. The consultant examined the patient, who was becoming restless, about midnight and ordered an EEG, brain scan and an anxiolytic. The neurosurgeon diagnosed concussion with left facial nerve contusion. During the night the patient continued to exhibit restlessness. He vomited and had tremors, which the staff caring for him attributed to alcohol withdrawal.

By morning the patient complained of headache and received acetaminophen. His restlessness increased throughout the second day and night; he was disoriented and incontinent. After a second examination the consultant noted that the patient was "stable with no lateralized findings." By the fourth day it became necessary to double the anti-anxiety agent and place the patient in restraints. The patient was confused and agitated and arousable only with great difficulty, but his pupils were brisk and reactive. An ophthalmologist was consulted for a possible eye infection, which was ruled out.

On the fifth day after admission the consultant and the hospital learned that the patient was unable to pay his bill and efforts to transfer him elsewhere were initiated. Over the next four days, until he was moved to another hospital, the patient deteriorated. He could not be aroused, was responsive only to painful stimuli and continued to be incontinent. His pupils were sluggish. At transfer he was very obtunded.

The diagnosis at transfer—At the second institution the patient was found to have left-sided face drop and no movement in his left arm and leg. His pupils were sluggish and he continued to be responsive only to painful stimuli. A second neurosurgeon was consulted and ordered an emergency CAT scan, which showed a large right intracerebral hematoma in the posterotemporal area. A craniotomy was performed that day. Five days later, the patient was up walking and talking. A subsequent EEG showed moderately severe bilateral cerebral dysfunction and focal epileptic form changes in two brain areas. Right foot drop was noted a month later.

The resulting claim—The patient sued the first neurosurgeon for negligent failure to diagnose a subdural hematoma and for willful and wanton abandonment. Punitive damages were sought. He alleged specific residual effects, including slurred speech, foggy memory, left leg problems and visual problems, seizure and personality disorders.

The outcome of the claim—The case was settled for $85,000 without punitive damages.

Why problems arose with this case—Every emergency patient should have a complete examination. In this case, a complete examination would have included an emergency CAT scan for comprehensive medical and neurological evaluation.

When a neurosurgeon was consulted and saw no focal neurological deficit, he did order a brain scan. But he compounded the problems of the first examination by failing to (1) order the scan as an emergency and (2) review it promptly.

Finally, this patient should not have been transferred. His condition was not stable and his diagnosis was not complete.

There were a number of reasons why this case was deemed not to be defensible, but perhaps most damaging was the evidence that patient treatment was determined by ability to pay. There is widespread societal objection to what is termed "patient dumping." Federal law specifies that no emergent patient can be transferred to another institution unless stable.

A patient's inability to pay should never compromise the quality and comprehensiveness of care provided in an emergency room or to emergent patients subsequently admitted to the hospital for follow-up care.

There should be no delay in properly evaluating and treating a patient, regardless of the circumstances.

Once treatment is initiated by a physician, the proper steps must be followed if that physician ceases to care for the patient. The patient, relatives or responsible friends must be notified that the physician no longer will serve as his physician. Notice should be sufficient to permit the patient to secure another medical attendant. Because the initial neurosurgeon had treated the patient, but never saw him again after transfer, he was vulnerable to a charge of patient abandonment.

Every effort should be made to substantiate a correct diagnosis. In this case, the initial diagnosis was incorrect. Although the emergency room physician and nurses at the first hospital noted left hemiparesis—a finding also noted by the second hospital—the first neurosurgeon continually noted that there were "no lateralized findings." It is possible that these lateralized findings were not apparent when he examined the patient because he was in restraints, but it does not minimize the effects of a missed diagnosis.

Intoxication should never preclude a competent neurological examination. Sometimes it is natural to attribute certain symptoms and signs to intoxication alone rather than to other causes. Intoxication is not cause to disregard symptoms and signs which would be immediate cause for concern in a sober patient.

It would have been very difficult to go to court with this case and argue that the diagnosis and treatment delay did not harm the patient or perhaps contribute to the patient's resulting problems. It is not possible to dispute that the longer a hemorrhage continues to compromise brain tissue, the more difficult it becomes to reverse the effect of any damage. Certainly, even if the delay did not lead to residual damages, it did cause the patient additional pain and suffering, generate additional medical and lost wage costs, all of which had to be factored into the final settlement. ▲

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

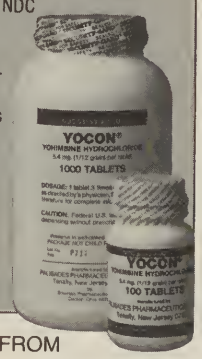
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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UI/Reese

(continued from page 3)

March 20 hearings held by the Black Caucus of the Illinois House of Representatives drew testimony consistent with that before the senate committee. According to Rep. Donne Trotter, (D-Chicago), who chaired that meeting, findings will be shared with a task force of House members recently convened by Speaker Michael Madigan to study the issue.

Rush initiative unexpected

When the university medical staff met on February 22 to propose an affiliation with Rush as an alternative to the Reese affiliation, Ikenberry dismissed the idea as "loose talk" designed to "produce confusion in the talks now ongoing" with Reese. Ikenberry also said that discussions with Rush had ensued last year, but that both institutions concluded that an affiliation was not in either institution's best interest.

Rush sources confirmed Ikenberry's assessment at that time. But in his letter two weeks later, Jannotta expressed concern that "the current plans for closing the University of Illinois Hospital do not assure continuity of care to our West Side community" and that the Reese proposal "undermines a long-held dream by civic planners that the West Side Medical Center District become a 'World Class Medical Center'."

"We reiterate our willingness to accommodate your clinical faculty at Presbyterian-St. Luke's Hospital, to integrate residency programs, and to explore consolidation of our health education programs," he wrote.

Trustee vote planned for April

The board ultimately deferred action on any aspect of the affiliation package. But, in so doing, they adopted a resolution reaffirming support for the plan, vowing to approve not only the Reese agreement, but also the affiliation agreement with Cook County and the "use agreement" for the university hospital at its April meeting in Chicago. If that occurs, the package will next go to the Cook County Board of Commissioners, and finally to Springfield for legislative implementation. ▲

Reese president addresses RPS

by Kevin O'Brien

UNIVERSITY of Illinois College of Medicine residents will experience little disruption in their training as a result of the proposed affiliation agreement with the Michael Reese Hospital and Medical Center, Reese President Henry L. Nadler, M.D. told the ISMS Resident Physicians Section (RPS) Governing Council on March 16.

"We believe that we have at least verbally tried to give every assurance that any resident in training will continue," without significant program changes, he said.

Dr. Nadler met with the RPS Governing Council at the invitation of Chairman Bruce Doblin, M.D., who cited a need for information regarding the proposed affiliation's potential effect on graduate medical education.

"There seems to be a great deal of speculation among resident physicians regarding the affiliation, with very little factual information known," Dr. Doblin wrote in his invitation letter. Dr. Doblin also invited University of Illinois College of Medicine Dean Phillip M. Forman, M.D., who was represented by University of Illinois Hospital Chief of Staff William G. Troyer, M.D.

Dr. Nadler acknowledged that some residents, especially those in OBGYN, may feel some hardship over the next two years. However, he stressed that the benefits of the proposed affiliation should be viewed in the long term.

"We truly believe that while there are going to be problems relating to this affiliation to a different degree in some of our lives, the end result will be a better educational service," Dr. Nadler said. He also offered to meet at any time with concerned residents to further explain the effects of the proposed affiliation on graduate medical education.

RPS Governing Council members reacted positively overall, although some were not entirely satisfied.

"It was the first time that people were honest and things began to make sense," said Gail Herman, M.D., a University of Illinois resident, adding that while potential problems remain, the session had "addressed some of our concerns and made people feel better."

Michael Reese resident Richard Quinones, M.D., pointed out that the Reese president has an effective track record as dean of the School of Medicine at Wayne State University. "I thought he answered the questions well, and I was satisfied with his answers," he said.

However, University of Illinois resident Gail Williamson, M.D. said evaluation of the Reese agreement is premature until the Cook County affiliation agreement is completed.

"Until they can guarantee a Cook County agreement, the big dream is not going to happen. I don't think they have grounds to say it is going to happen," said Dr. Williamson.

"I think he has the interests of the residents at heart and he will build a stronger educational institution," said Dr. Doblin after the meeting, adding that Dr. Nadler seems to have a good grasp of issues, but that much still needs to be done. "It's up to him, how he responds," the RPS chairman concluded. ▲

News Capsules

Members in the news

Jacek "Jack" Franaszek, M.D., Naperville, was recently elected president of the board of directors of the American College of Emergency Physicians. Dr. Franaszek is affiliated with Hinsdale Hospital and the Bolingbrook Medical Center, where he has practiced emergency medicine since 1986. . . . The DuPage County Medical Society recently installed **Patricia A. Merwick, M.D.** as president and named E. Eliot Benezra, M.D. as president-elect. Dr. Merwick, Elmhurst, is affiliated with Elmhurst Memorial Hospital and is on the board of directors of Western DuPage Special Recreational Association. Dr. Benezra, Oak Brook, is on the staff of Elmhurst Memorial, Riveredge, Good Samaritan and Rush-Presbyterian St. Luke's Hospitals.

Meetings and announcements

The 1989 Illinois Society of Medical Assistants convention, hosted by the Rock Island County Chapter, will be held April 27-30 in Moline. Clinical and administrative sessions will be offered and exhibits demonstrating the latest in office automation will be featured. For information please contact: Roxanne Steffens, CMA, c/o Bruce Steffens, M.D., 615 35th Ave., Moline, (309) 762-1875. AAMA membership information may be obtained from Robin Bluestein, president, 10471 Dearlove Rd., #1B, Glenview, IL 60025.

The Illinois/Great Lakes chapters of the American College of Utilization Review Physicians' regional seminar will be held April 30 at the Holiday Inn Crowne Plaza, Lisle. The theme will be quality assurance into the 1990's—a futuristic approach. Local experts will be featured as speakers.

The 1989 Annual Conference and Meeting of the American Academy of Pain Medicine (AAPM) will be held November 3-4 at the Grand Kempinski Hotel in Dallas, Texas. For more information please contact the AAPM at (312) 645-1078.

The Illinois Cancer Council's spring clinical trials meeting will be held April 19 at the American Hospital Association in Chicago. The topic of this one-day conference will be chemoprevention and will feature Dr. Peter Greenwald, the National Cancer Institute director of cancer prevention and control, as well as nine other speakers. For more information please contact Sharon Talarek at (312) 346-9813.

The 1988 Report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (JNC IV) is now available from the National Heart, Lung and Blood Institute (NHLBI). JNC IV reviews, updates and expands the 1984 recommendations for controlling hypertension. It is intended as a guide for practicing physicians and other health professionals in their care of hypertensive patients and as a reference for those participating in a community hypertension control program. Copies may be obtained at no charge by contacting: The National High Blood Pressure Education Program, Information Center, 4733 Bethesda Ave., Suite 530, Bethesda, MD 20814; (301) 951-3260. ▲

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July 28-29, 1989

Specialty Review in Internal Medicine
August 6-13, 1989

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Demonstrates efficacy comparable to that of the beta-blockers and diuretics in a wide range of patients.[2-5]

Rarely associated with fatigue, drowsiness, depression, constipation, sexual dysfunction, or postural hypotension.[2-5,7-8]*

Maintains or improves exercise capacity.[8]

*Please see Adverse Reactions section of brief summary.

Starting Dosage:



90 mg bid†

Also available: 120-mg capsules

†Dosages must be adjusted to each patient's needs, starting with 60 to 120 mg twice daily.

BRIEF SUMMARY
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CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node retractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGOT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in some cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects

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Maintains renal function with no disturbance of fluid or electrolyte balance.[10]

Reduces left ventricular hypertrophy[6] and has no adverse effects on serum lipids.[2,5,11]

increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Anesthetics: The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the pennatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing. The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system; these include any adverse reactions seen in angina studies that were not observed in hypertension studies. In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie, greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%).

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS

Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS (continued)

ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
somnolence	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) or have been observed in angina trials. In many cases, the relation to drug is uncertain.

Cardiovascular: Angina, arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.

Nervous System: Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor, abnormal dreams.

Gastrointestinal: Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT, and LOH (see hepatic warnings), vomiting, weight increase, thirst.

Dermatological: Petechiae, pruritus, photosensitivity, urticaria.

Other: Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarticular pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

References: 1. Staessen J, Fagard R, Lijnen P, et al: *Pract Cardiol* 1986;12(5):55-65. 2. Massie B, MacCarthy EP, Ramanathan KB, et al: *Ann Intern Med* 1987;107(2):150-157. 3. Weir MR, Josselson J, Giard MJ, et al: *Am J Cardiol* 1987;60:36I-41I. 4. Frishman WH, Zawada ET Jr, Smith LK, et al: *Am J Cardiol* 1987;59:615-623. 5. Pool PE, Seagren SC, Salel AF: *Am J Cardiol* 1985;56:86H-91H. 6. Amodeo C, Kobrin I, Ventura HO, et al: *Circulation* 1986;73(1):108-113. 7. Pool PE, Seagren SC, Salel AF: *Cardiol Board Rev* 1986;3(10):77-91. 8. Sztajzel J, Hirsch AT, Tubau JF, et al: *Am J Cardiol* 1987;59:393-399. 9. O'Rourke RA: *Am J Cardiol* 1985;56:34H-40H. 10. Sunderrajan S, Reams G, Bauer JH: *Hypertension* 1986;8:238-242. 11. Schulte K-L, Meyer-Sabellek WA, Haertenberger A, et al: *Hypertension* 1986;8:859-865.

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Discipline

(continued from page 1)

Joseph B. Perez, M.D., a Rockford physician and member of the board. The disciplines can range from a simple reprimand to probation, suspension, fine, or—in the worst case scenario—license revocation.

"Physicians need to know that the board works for them," says board member Biswamay Ray, M.D. of Oak Brook. "Most don't concern themselves with the work of the board because they practice good medicine."

"The important thing," adds board member Warren Staley, M.D., of Chicago, "is to educate physicians about the changes in the law. Some are not fully aware that they can be penalized for failing to renew their license, for example."

Complaints against physicians come to the board from a variety of sources, including other physicians, patients, insurers and hospitals. The majority are reviewed and dismissed by the board due to lack of information, absence of statutory basis or insufficient cooperation from complaining parties.

"We met the other day and had 36 complaints in front of us," says Dr. Perez. "Thirty were dismissed right there without further action, but six were sent on for further investigation. I would say only 1% to 2% of all complaints end up in prosecution."

Maureen Mulhall, administrator of the Medical Practice Act, says the Illinois Department of Professional Regulation [IDPR] probably closes two of every three cases opened for lack of legal grounds to prosecute under the Act.

Dale Breaden, associate executive vice president of the Federation of State Medical Boards, estimates that national numbers show five to 10 informal actions for every one disciplinary action actually taken against an offending physician. For example, he notes that there were 2,302 disciplinary actions taken against physicians in 1986, the latest year in which complete data are available. But, he explains, that number probably represents some 12,000 informal actions against physicians nationwide.

The process

How does the whole, fairly complex, process work? It begins with a complaint to the IDPR Chicago or Springfield medical disciplinary section, staffed by medical coordinators Chauncey Maher, M.D., in Springfield and Kenneth G. Eggen, M.D., in Chicago. The complaint can be in the form of a telephone call or a letter from a citizen, another physician or a state agency.

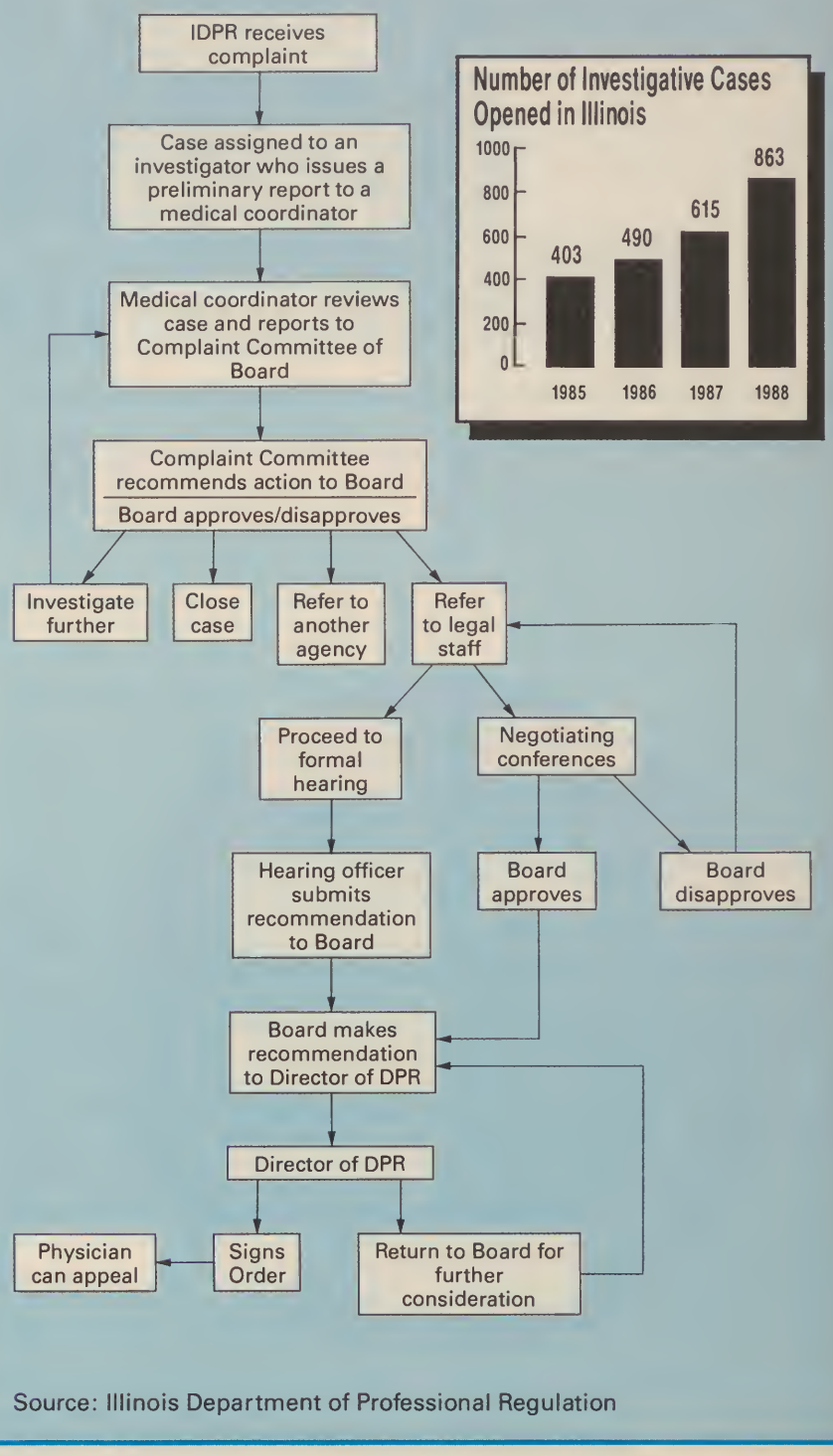
The biggest volume of cases comes from mandatory reporting, which is required in five specified instances, including malpractice claim settlements. Insurers who pay a claim on behalf of their insured physician must then notify IDPR of that amount along with the alleged wrongdoing.

Professional societies and hospitals also report incidents of unprofessional or improper conduct which lead to sanctions against physician privileges or membership. The medical coordinators typically review the medical records and investigative reports and write a formal recommendation. Physicians named in such complaints or reports are given an opportunity to respond to the allegations. "We receive probably 50 to 100 physician responses to these mandatory reports every month," Dr. Maher says, adding that the case is reviewed and either opened or closed depending on the facts. "The majority of investigated cases do not involve a violation of the Medical Practice Act," he adds.

If a case is opened, an investigator is assigned to the file. The medical coordinators review the findings and write an opinion, which is sent on to a complaint committee composed of

(continued on page 13)

Illinois Department of Professional Regulation Physician Disciplinary Process



Source: Illinois Department of Professional Regulation

Medical Practice Act Changes

"These changes should allow the Illinois Department of Professional Regulation and its Medical Disciplinary Board to address issues of physician impairment or unprofessional conduct, to involve the profession to a greater extent in the investigation and solution of problems, and to expedite review."

—Report of the Task Force on Medical Discipline to Governor James R. Thompson, April 9, 1986.

Physicians who take a look at the new Medical Practice Act will see plenty of changes. Key among them is an expansion of the statute of limitations for disciplinary investigations and action.

Under the new reform, the Medical Disciplinary Board has three years to act from the time a complaint is received, and up to five years from the date of the incident.

Another important change has to do with access to medical records. The new law gives the Medical Disciplinary Board the right to subpoena patient records when a complaint comes from the mandatory report required from hospitals, insurers and others. Confidentiality is protected and so is the Board's access to essential information forming the grounds for investigations and discipline.

Other changes:

- The new law allows the Medical Disciplinary Board to enter into agreements with state and local associations to assist the board in the investigation of complaints that might be grounds for future discipline. Under the Act, confidentiality and immunity are given to organizations reviewing complaints on behalf of the Medical Disciplinary Board.
- The Hospital Licensing Act was amended to require that hospitals query the IDPR as to the status of a physician's license before granting an applicant medical staff privileges.
- The new Act gives the Disciplinary Board automatic review of impaired physicians and says that a disciplined physician who prematurely leaves a rehabilitation program should automatically be subject to a hearing.
- The Medical Disciplinary Board is also authorized to issue an order for reviewing the physical premises of a physician's office, if the Board determines that probable cause exists.
- The Medical Practice Act gives statutory authority for coordinated investigation of a practitioner who is guilty of violating state law, whether it be for Medicaid fraud or any other state agency investigation.
- Under the "grounds for discipline" portion of the Medical Practice Act, the clause "gross or repeated malpractice resulting in serious injury or death of a patient" has been stricken and instead replaced with a "gross negligence" standard.
- Portions of a model medical practice act developed by the Federation of State Medical Boards of the United States, were used to revise sections of the Illinois Medical Practice Act where the model was deemed more concise and understandable.
- Regulatory changes resulting from the new Act include a provision to permit the Medical Disciplinary Board, when asked by a licensed health facility, to identify whether any disciplinary action has ever been taken against a physician and also whether the individual is being monitored and under a rehabilitation program. (In the past, hospital staffs were unable to know if an individual applying for staff privileges was undergoing therapy for addiction because the Board wasn't authorized to release information about individuals).
- The new Act also provides for a special physician board to examine clinical competence in cases in which a physician is accused of providing improper clinical service.
- Finally, the Department can now impose monetary fines, either alone or in conjunction with another form of discipline. Monies collected from fines are designated for the Medical Disciplinary Fund and are not to exceed $5,000 per offense. ▲

(continued from page 12)

board members and IDPR staff. The committee may decide there is no basis for any disciplinary action, file a formal complaint, or send the matter on for further investigation. The Medical Disciplinary Board reviews the case for a final decision.

"Most of the time there is an informal discussion or conference with a board attorney and the physician and his counsel," says Dr. Eggen. That confidential informal hearing is not open to the public, and it is not a part of the doctor's record, says Otto Brosius, M.D., a retired physician from Decatur who sits on the board.

"If we don't settle the matter behind the scenes at the informal hearing, then the matter goes to a formal hearing, which is open to the public. Fortunately, most of these conferences end up in a consent order or agreement, which often includes a fair penalty, and most don't go any further," adds Dr. Brosius.

For example, a physician found to be impaired by drugs or alcohol would probably be put on probation if he or she agreed to enter a treatment center, says Dr. Brosius. "We do try to rehabilitate whenever possible. We do not want to take a physician's license away."

As a senior member of the disciplinary board, Chairman Robert Hambrick, D.O., from Burr Ridge, is a firm believer in the value of enforcement.

"When it comes to physicians doing things that can be harmful to the public or when they just don't care about the law, you just can't be too tough on those cases."

"But we also want to identify and help the impaired physician; we want him or her to be able to get help and return to practice," adds Dr. Hambrick.

"We don't want to hurt anyone; we just want to be fair. And the board takes its job very seriously, not only in being fair, but in being consistent in its disciplinary actions. When you look at the founded versus unfounded complaints, you can see that, by and large, the medical community is doing a good job," he adds.

On the whole, says Dr. Eggen, physicians have accepted the board's efforts quite well. Steve Selcke, director of the Illinois Department of Professional Regulation, agrees. "Physicians in compliance with the Act do appreciate what we're trying to do. The good practitioner gets his or her reputation tarnished by the 'bad apple'."

History of changes

On May 22, 1987, for the first time in more than 60 years, the Medical Practice Act was updated and disciplinary measures were strengthened and expanded to give the state—and physicians themselves—a broader hand in weeding out doctors who engage in unethical, illegal or incompetent activities.

Coincidentally, physicians may recall that the fee for their three-year license nearly tripled to $300 on that same day. They may not know that the state targeted much of that increased license fee revenue to nearly triple the number of medical investigators and attorneys within IDPR, which is responsible for enforcing the Medical Practice Act.

In fact, the number of medical investigators went from 12 to 32 while the number of attorneys prosecuting complaints against physicians jumped from 3 to 10, says Mulhall, the IDPR staff attorney who is charged with administering the Medical Practice Act.

Additionally, IDPR hired Dr. Eggen, a retired physician, as a medical coordinator in Chicago, to complement a chief enforcer of medical discipline in the state's Springfield office.

Not surprisingly, with the new law and added personnel in place, the number of cases opened and disciplinary actions taken is on the rise. Prior to the 1976 creation of the Medical Disciplinary Board, only three to five disciplinary actions were taken annually. There were 49 disciplinary actions taken in 1984, 75 disciplinary actions taken in 1985, and 126 actions taken in 1986.

But Mulhall predicts that, with increased staffing and beefed up enforcement, it's very likely the number of cases will increase significantly in 1989 and beyond.

"I see 1988 as a year of housecleaning," adds Mulhall. "In 1989, we'll have a greater ability to use the grounds of discipline. Generally, the number of complaints we investigate has dramatically increased." Mulhall says the agency is taking a more proactive approach now permitted under the new Act, and not waiting for the public to initiate complaints. IDPR Director Selcke agreed that the new Act makes the Department more effective.

"All the parties agreed we wanted to bring Illinois into the forefront of states which have oversight of the profession," he said. "Now, we have the enforcement capabilities, as well as the added staff to handle the increased caseload."

He says to expect more part-time suspensions and revocations rather than the traditional reprimand or slap on the wrist. "Now, we have the tools to implement these stricter forms of discipline," Selcke concluded.

"Our major concern in rewriting the Medical Practice Act was improving the disciplinary process," says Alfred J. Clementi, M.D. a trustee and former chairman of the Illinois State Medical Society Board, who served as chairman of the Governor's Task Force on Medical Discipline. And, Dr. Clementi concludes, while some provisions could generate debate, "I think most physicians feel it's for a good cause." ▲

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(continued from page 1)

asked if he is a doctor, and the U.S. Marine Corps orthopedic surgeon, Boone Brackett, M.D., with one universal gesture, lets her know her journey had been worth every step.

That was in late 1968. Like the people in Kentucky's Blue Ridge Mountains he'd treated before joining the military, Dr. Brackett remembers the Vietnamese as, "having an almost religious, 100% trust in the 'Bok-Sies.' There was never any question. In both cultures there was a feeling for the physician that was like a covenant. It was a trust you just didn't betray."

Twenty-one years later he brings those observations to a discussion about defensive medicine. He wonders if there isn't something peculiar to modern American culture which forces physicians to "construct a defense in the process of treating a patient."

He's not alone. Many physicians practicing today ask a similar question. Is there something about the rise in consumerism; media coverage of medical malpractice suits and damage awards; or perhaps a climate of social suspiciousness that makes "100% trust" such a scarce commodity?

Alfred J. Clementi, M.D., who chairs the Illinois State Medical Insurance Services' Loss Prevention Committee, believes that physicians need to recognize and adapt to structural changes in the physician-patient relationship. "It's okay for physicians to be challenged and questioned by patients," he says. "It may require a bit of a thicker skin, but that kind of permission allows for more dimensions in the doctor-patient relationship."

"Always do right. It'll gratify some people and astonish the rest."—Mark Twain

Patient attitudes have been influenced by revolutionary shifts in the nature of medical practice, including increased technology and subspecialization. Dr. Clementi observes that layers of subspecialization can create barriers to patient communication.

"The growth of subspecialties is a natural result of medicine's increasing body of information," he says. "That will probably continue into the future. However, there's a factor which accompanies the growth of subspecialization which has a bearing on defensive medicine. The subspecialist needs to understand that he or she faces a greater challenge in relating to patients than, for example, family practitioners," who have more direct patient contact.



Boone Brackett, M.D.



Boyd McCracken, M.D.

"They have very limited exposure to a human being they will be caring for," Dr. Clementi says. How that fractional bit of time is managed has a lot to do with the patient's level of comfort, sense of security, confidence, and feeling of rapport with the doctor. If an MD approaches a patient tentatively, guarding, self-protective, and full of defenses, there will be immediate barriers to the give-and-take necessary for a smooth relationship. It is likely, in the event of anything other than a perfect result, the patient will remember the barriers as well as the person who constructed them.

"Very often, patients don't trust their own ability to evaluate physicians," Dr. Clementi says. "Emotional walls only compound this problem. My own advice is to practice medicine as if you're treating someone you love and really care for. Spend time. Show concern. Conduct yourself as if you're practicing on someone with whom you have a personal relationship. Granted, you're a little more vulnerable, and it's going to hurt more if a patient turns around and sues you. But in the end you'll be better for the openness."

Harold Jensen, M.D., chairman of the ISMS Board of Trustees, agrees that changes in the medical environment have produced unavoidable behavioral responses. "Today," he says, "as a result of those influences, there is a restriction on the style and manner with which the practicing physician treats patients. Documentation and confirmation have become key words in the MD's vocabulary."

"In the past decade the broad privileges of the primary physician have been sequestered. Now these are in the hands of the subspecialist who will ultimately confirm the instincts and opinions of the primary MD. That adds an extra layer of verification which, should the need require, can be brought into a trial."

"In a profession known for its groundbreakers, it is arguable that the day of the risk-taker may be on its way out. Instead, our profession runs the risk of developing the mentality of (highly educated) nine to five clerks. Thirty years ago a doctor would have been looked on with disdain if he or she came into the field saying, 'I don't want weekend call,' and 'what about vacations.' But, in all fairness, 30 years ago, the emotional costs of functioning in this profession were considerably less."

Dr. Brackett agrees and worries about technology's usurping the roles gut instinct and experienced insight play in a practitioner's life.

We find the physicians who put technical ability and intellectual acumen ahead of understanding and compassion for the patient are the ones at greatest risk of being sued.



Alfred J. Clementi, M.D.

"The arthroscope," he argues, "is a good example. I and my peers were trained to tell by palpation whether, for instance, a knee cartilage was torn on the medial or lateral side. In that respect, the physical examination was an important and reliable diagnostic tool."

"But that was at a time when we were much less concerned with the question of, 'how can I explain this decision to a jury?' Then, our only consideration was the patient; not the documentation and not how something could be defended in court."

James S. Todd, M.D., senior deputy executive vice president for the American Medical Association, believes validation is a critical factor in defensive medicine. "Not only are physicians encouraged to run every conceivable test, but they are on safer legal ground if they can show they've asked someone else's counsel at the outset. This challenge to self confidence is but one result of the hostile legal environment."

Documentation and confirmation have become key words in the MD's vocabulary.

Boyd McCracken, M.D., is a southern Illinois family physician who chairs the Policyholder Services Committee of the Illinois State Medical Inter-Insurance Exchange. That job has sensitized him to cultural changes in the medical environment.

"The way we look at it, everything we do is an element of defensive medicine," Dr. McCracken says. "We talk about risk management, but that's only a part of it. We also encourage physicians to stay current in their continuing medical education courses," Dr. McCracken continued, "to be aware of information which is commonly omitted from the medical record, and to look with us at the trends we see in law and medicine."

"Most of all," he says, "we stress the importance of the physician-patient team concept. We ask doctors to give patients the extra time they need. We find the physicians who put technical ability and intellectual acumen ahead of understanding and compassion for the patient are the ones at greatest risk of being sued."

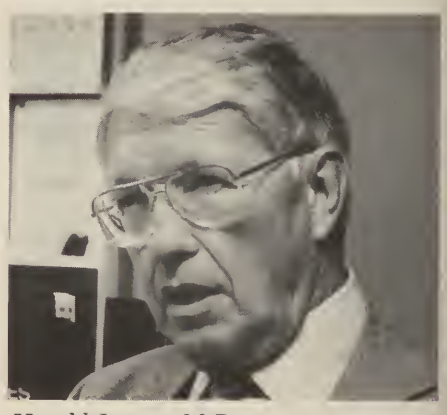
Dr. Todd puts it another way. "All physicians should know that patients come to attorneys more angry than injured," he says. "Simply stated, happy patients don't sue doctors."

Dr. McCracken believes there's work to be done on the patient education side as well. "Regardless of their level of knowledge or sophistication, patients should know that every outcome is not going to be a perfect one. Unfortunately, they've been conditioned by the media and society to equate a bad result with negligence. That simply isn't the case."

"It's systemic," observes Dr. Jensen. "Society makes an effort to help those who are injured and looks to the courts to be the arbiter. But you have to recognize that if potentially compensable events in a hospital are around one in twenty, and the actual rate of suit is one in a hundred, then that means four out of five are not in a system that's supposed to be working for them."

"We know the system works for higher awards as determined by the attorney. We know low awards aren't worth his effort. That makes the system of 'making the patient whole' very selective and conceivably dysfunctional. Still, it's the worry that this case will be that one-in-a-hundred. And, as Dr. Jensen observes, it's an expensive one percent.

"In addition to the attention to careful documentation; excessive reliance on specialists and subspecialists; using technology to confirm clinical judgment; and extra hospital days, there are other costs. When a physician gets sued, fear becomes part of the cost of doing business. A lawsuit brings personal integrity into question. What a suit says is, 'you missed something every other doctor would have found.' It's an assault on a person's integrity. And, for many physicians, integrity is the only thing that keeps them practicing."



Harold Jensen, M.D.

Dr. Brackett remembers the openness and accessibility of the physician who took care of his family when he was growing up. "Dr. Brown, a general practitioner, was a wonderful guy, and the reason I went into medicine. He was a caring person who was committed to helping people help themselves. More than anything else, I remember how much he cared about us, and how committed he was to doing what's right."

"In my work with residents, I remember the example he set and the way it affected me. . . . I also remind them of what a medical school professor of mine once told me. Quoting Mark Twain, he said, 'Always do right. It'll gratify some people and astonish the rest.' " ▲

Obituaries

***ANDERNOVICS**
Dr. Budris Andernovics of Industry, died November 12, 1988 at the age of 67. Dr. Andernovics was a 1950 graduate of the University of Wuerzburg Medical School, Wuerzburg, Germany.

CZOPIWSKY
Dr. George Czopiwsky of Zion, died August 14, 1988 at the age of 65. Dr. Czopiwsky was a 1948 graduate of Medizinische Fakultat der Ludwig Maximilians Universitat, Munich, Germany.

****EFFRON**
Dr. David V. Effron of Scottsdale, Arizona (formerly from the Chicago area) died December 24, 1988 at the age of 85. Dr. Effron was a 1932 graduate of the University of Illinois Medical School, Chicago.

ESPERNE
Dr. Miguel Esperne of Silvis died August 10, 1988 at the age of 86. Dr. Esperne was a 1932 graduate of the Facultad de Medicina, Universidad de Buenos Aires, Argentina.

***FURRIE**
Dr. James M. Furrie of Springfield died December 12, 1988 at the age of 74. Dr. Furrie was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

****HODEL**
Dr. Esther S. Hodel of Carlsbad, New Mexico (formerly of Morton) died November 8, 1988 at the age of 86. Dr. Hodel was a 1931 graduate of the Women's Medical College, Medical College of Pennsylvania, Philadelphia.

HOLTZMAN
Dr. Samuel Holtzman of Park Ridge died August 31, 1988 at the age of 92. Dr. Holtzman was a 1928 graduate of Northwestern University Medical School, Chicago.

MALIK
Dr. Robert L. Malik of Chicago died December 12, 1988 at the age of 30. Dr. Malik was a 1983 graduate of Case Western Reserve University, Cleveland, Ohio.

****MASUR**
Dr. Walter W. Masur of Chicago died September 5, 1988 at the age of 74. Dr. Masur was a 1937 graduate of Medizinische Fakultat, Universitat Bern, Switzerland.

NAUGHTON
Dr. Thomas J. Naughton of Chicago died August 19, 1988 at the age of 74. Dr. Naughton was a 1940 graduate of Loyola University Stritch School of Medicine, Maywood.

***NEUFELD**
Dr. Evelyn A. R. Neufeld of Harvey died December 12, 1988 at the age of 89. Dr. Neufeld was a 1933 graduate of the University of Health Sciences/Chicago Medical School, North Chicago.

***NORBERG**
Dr. Clarence A. Norberg of Sun City, Arizona died September 11, 1988 at the age of 74. Dr. Norberg was a 1943 graduate of Northwestern University Medical School, Chicago.

***RICHARDS**
Dr. Gordon L. Richards of Wilmington died December 19, 1988 at the age of 74. Dr. Richards was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***RICHMOND**
Dr. Glen H. Richmond of Naperville died November 27, 1988 at the age of 67. Dr. Richmond was a 1947 graduate of the University of Virginia School of Medicine, Charlottesville.

***ROSE**
Dr. Raymond F. Rose of Western Springs died December 10, 1988 at the age of 70. Dr. Rose was a 1943 graduate of Washington University School of Medicine, St. Louis.

SCHERIBEL
Dr. Karl J. Scheribel of Chicago died August 23, 1988 at the age of 80. Dr. Scheribel was a 1932 graduate of Loyola University Stritch School of Medicine, Maywood.

***STEWARD**
Dr. Lee A. Steward of Mattoon died December 19, 1988 at the age of 72. Dr. Steward was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

****SWANSON**
Dr. A. Martin Swanson of Rockford died December 8, 1988 at the age of 97. Dr. Swanson was a 1919 graduate of Northwestern University Medical School, Chicago.

****TALLAT-KELPSA**
Dr. Florian Tallat-Kelpsa of Evergreen Park died September 10, 1988 at the age of 94. Dr. Tallat-Kelpsa was a 1926 graduate of Vytauta Didziojo Universiteto Medicinos Fakelteto, Kaunas, Lithuania.

VENTURA
Dr. Luis Ventura of Edwardsville died August 28, 1988 at the age of 62. Dr. Ventura was a 1953 graduate of Instituto Tecnologico de Santo Domingo, Dominican Republic.

****WRIGHT**
Dr. William E. Wright of Sterling died August 7, 1988 at the age of 95. Dr. Wright was a 1920 graduate of the University of Illinois College of Medicine, Chicago.

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Champaign hospital wars end in new consolidation

by Janice Rosenberg

IN CHAMPAIGN, the complicated case of city-owned Burnham Hospital is at last resolved. On February 7, the City Council voted 5-3 with one member absent to approve a "Memorandum of Understanding" to consolidate Burnham with Kankakee-based ServantCor's Mercy Hospital in Urbana.

"It's an outstanding achievement," said Champaign Mayor Dannel McCollum, who said that it was a difficult process because one institution was public and the other religious. ServantCor is a health care corporation owned by the Servants of the Holy Heart of Mary.

McCollum said that the two staffs will begin work on a master consolidation agreement that is expected to be ready within six months. A transition team has been appointed to oversee the consolidation. This team will eventually comprise the governing board of the new institution, he said.

"I think it's sad," said Robert Brunner, M.D., who headed a group of independent doctors who tried to lease Burnham Hospital. "I think this is a blow for independent doctors and medicine in this town. I think that 10-15 years from now, we're going to see big corporate hospitals and two big clinics and that's it. As for truly independent medicine here, I think that's going to be no longer around."

A long and winding road

For a time after the city announced its determination to remove itself from the business of running a hospital, purchase of Burnham by the local Christie Clinic seemed likely. However, in early November of last year, Christie rejected that possibility.

Next, ServantCor and the city of Champaign worked out a proposal describing the consolidation of Burnham and Mercy. Last November, city officials called an open meeting to make this "Memorandum of Understanding" known to the public. According to Mayor Dannel McCollum, the city received more letters on this issue than on any other in his political career.

The City Council decided to allow the Burnham Hospital Board time to formulate any problems and solicit any other proposals that might have some chance of success. The Council placed two restrictions on the Board. According to Mayor McCollum, "They could not go back to Christie and sweeten the deal, and a continuation of the hospital with its current market share was not an alternative."

To counter ServantCor, a group led by independent doctors worked out a proposal requesting that the City Council allow them to lease Burnham Hospital. This group included some doctors from Christie Clinic, numerous employees of Burnham Hospital, and other interested investors.

"We feel that Burnham Hospital has a character that is unique," said Dr. Brunner. "Many townspeople and rural folks have gone to Burnham for years. They feel that it has a certain personalized quality to it."

Burnham Hospital is the oldest in the city. It has always taken care of the indigent. The independent group did not want to see it become part of a large corporation. "We've been battling City Hall to keep Burnham viable," Dr. Brunner said. "I think Burnham has had an excellent quality of patient care over the years. It's truly a hospital for all the people."

Other concerns about the proposed memorandum were voiced by Carol Gapsis, district eight councillor for the Illinois State Medical Society Auxiliary. She considers the loss of reproductive services in the Champaign-Urbana area a major problem in the ServantCor consolidation proposal. If ServantCor, a Catholic corporation, ran Burnham Hospital it would not offer abortions, sterilization, or infertility procedures.

Mayor McCollum, who admits that this issue is highly charged emotionally, does not agree. "Most reproductive procedures are office calls," he says. "We've ascertained that all procedures currently being done in Champaign would continue."

In December, the independent group presented their proposal to the Burnham Hospital Board.

On January 10, 1989, the Board presented its critique of both the ServantCor memorandum, along with the independent doctor's plan, to the City Council. After a few study sessions, the Council accepted the ServantCor proposal.

Dr. Brunner said that the Mayor never showed any interest in hearing the independent doctors' suggestions for making Burnham Hospital work. "We feel errors have been made at the hospital," Dr. Brunner said. "If new management could be allowed to turn some of these things around it could be viable. But the Mayor's office feels it's too late for that. He is going to push ahead and create this new entity despite the divisiveness that this episode has caused in the medical community."

Not all of the independent doctors feel as downhearted about the situation. Lewis Trupin, M.D., pointed out that the City Council chose to take the memorandum only after it had been greatly modified to assure care to the indigent and maximize the opportunity for employees at Burnham to retain their positions and be treated on an equal basis with employees at Mercy.

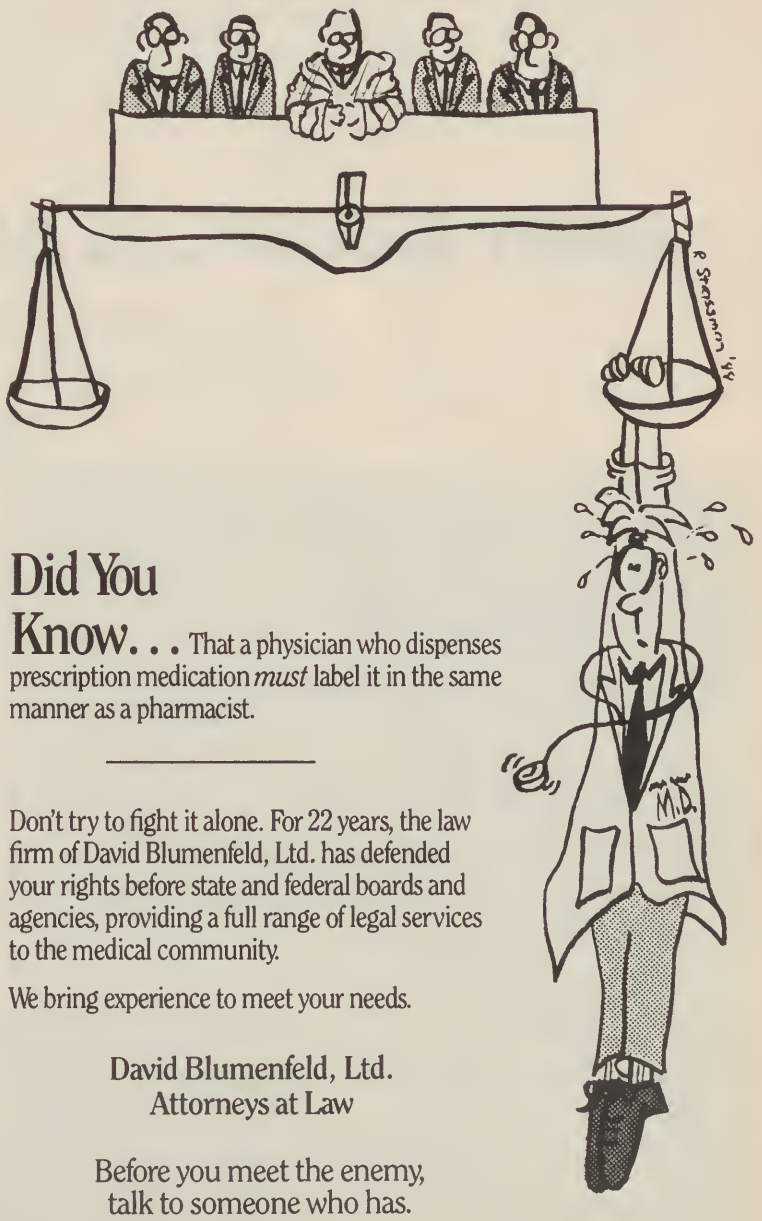
On the issue of reproductive services, Dr. Trupin, an obstetrician, said, "The mayor, the City Council, the independent physicians, Christie Clinic, and Carle Clinic have all gotten together to try to find an alternative mechanism of providing reproductive services. This hasn't been fully worked out but I'm 100% confident that it will be." ▲

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Annual Meeting

(continued from page 1)

lution 31. The Will-Grundy County Medical Society is asking ISMS to study how retired physicians can be used to improve access to care and enhance the image of the medical profession in Resolution 51, and for eligible physicians to join the American Association of Retired Persons in Resolution 52.

Reference Committee B

Two resolutions deal with giving patient information over the telephone. Resolutions 16, from the Cook County Delegation, and 48, from the Kane County Medical Society, call on ISMS to work for solutions to the problem of third party payors inappropriately requesting confidential patient information over the phone. Resolution 33 from the Jackson County Medical Society calls on ISMS to work toward solutions to access problems in rural obstetrical care, including encouraging physician-nurse/midwife teams to work in rural areas through contractual mechanisms allowing for reimbursement and covering medical malpractice costs. Several resolutions call on ISMS to work with state government to increase funding for public aid, the uninsurable, and the medically indigent.

Reference Committee C

The ISMS Board of Trustees in Resolution 15 advocates state legislation requiring that hospital medical staffs establish a committee to shepherd activities concerning the physical and mental health of medical staff members. The resolution also asks the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to institute a similar requirement. Resolution 32 from the Jackson County Medical Society encourages certified birthing centers for low-risk obstetrical patients in rural Illinois communities. Resolution 38 from the Winnebago County Medical Society calls on ISMS to study implementation of remedial medical education programs in Illinois, in light of the various non-physician review organizations currently involved with medical practice deficiencies. Resolution 56 from Biswamay Ray, M.D., a delegate from the Chicago Medical Society and a member of the state's Medical Disciplinary Board, asks ISMS to support the concept at the AMA level of a single pathway examination equivalent to the National Board of Medical Examiners Parts I, II, and III for both domestic and foreign medical graduates.

Reference Committee D

Several resolutions dealing with smoking will be considered by Reference Committee D. Resolution 39 from the Winnebago County Medical Society wants ISMS to ask the AMA to support federal legislation requiring tobacco product manufacturers to print the Surgeon General's warning in red on all tobacco packages. Resolution 41 from the Resident Physicians section asks ISMS to urge Illinois hospitals and, through the AMA, the JCAHO-accredited hospitals to establish a non-smoking policy, including a complete ban on smoking in patient-care areas.

Resolution 18 from the DuPage County Medical Society calls on ISMS to support state legislation that explicitly defines hazardous medical waste and guidelines for its proper disposal. Resolution 24 from the Rock Island Medical Society calls on the ISMS to support increased taxes on alcoholic beverages to fund the care of highway trauma victims. Resolution 35 from the Jackson County Medical Society asks ISMS to support the conversion of abandoned rail lines to recreational and historic trails by the Illinois Department of Conservation.

Constitution and ByLaws

Resolution 9 establishes the *Illinois Medicine* Committee in the ISMS Bylaws and Resolution 13 states the purpose of *Illinois Medicine*. Resolution 2 authorizes the Board of Trustees to fill vacancies in either the ISMS first or second vice president offices by appointing a physician to complete the remainder of the term.

The Annual Meeting is open to all ISMS members. For further information, call 312-782-1654 or 1-800-782-ISMS. ▲

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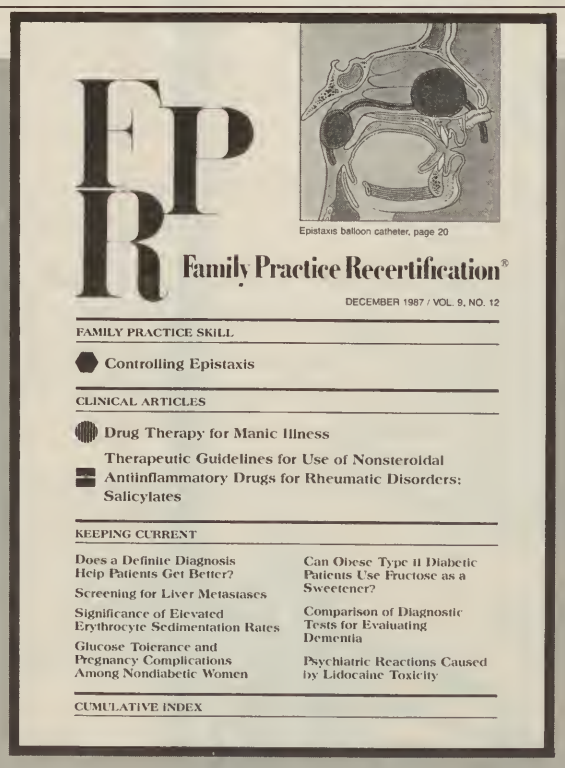
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Auxiliary Annual Meeting April 6-7

The Illinois State Medical Society Auxiliary (ISMSA) will hold its annual meeting in conjunction with the ISMS House of Delegates at the Westin O'Hare Hotel in Rosemont.

The ISMSA House of Delegates will convene Thursday morning with a keynote address by Mrs. Mary Strauss, president of the American Medical Association Auxiliary. Mrs. Strauss brings experience and commitment in education of gifted children to her AMAA leadership role. Reference committee hearings will follow her keynote address.

The annual ISMSA Humanitarian Awards will be presented at Thursday's luncheon. This year's recipients are Mrs. Christine McCarty, Winnebago County, in the member category, and Paul R. Blough, M.D., Peoria County, in the non-member category. County auxiliary efforts in AMA-ERF health projects, legislation and membership will also be recognized.

Sara Charles, M.D., associate professor of clinical psychiatry at the University of Illinois College of Medicine, Chicago, will that afternoon address family stress associated with medical malpractice litigation. Dr. Charles, whose research in this area is well respected, co-authored "Defendant: A Psychiatrist On Trial For Medical Malpractice," with her husband, Eugene Kennedy.

On Friday morning, the Adams County Auxiliary's Spouses Offering Support (SOS) Group will present guidelines to help fellow auxiliary members cope with stress. At the closing luncheon later that day, outgoing President Sherry Betsill, Springfield, will recap the year's events and induct Nancy Hoffmann, Rockford, into office as 1989-1990 ISMSA president. The ISMSA annual meeting is open to all Auxiliary members and physician spouses. Persons interested in attending may obtain further information through the headquarters offices: 312-782-2099. ▲

Classified Advertising

Send all advertising orders, correspondence and payments to: *Illinois Medicine*, Twenty North Michigan Ave., Suite 700, Chicago IL 60602. Telephone: 312/782/1654; 1/800/782/ISMS. *Illinois Medicine* will be published every other Tuesday. Ad copy with payment must be received at least four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

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ISMS urges "Substandard Care" rules revision

THE ILLINOIS State Medical Society (ISMS) has urged the Health Care Financing Administration (HCFA) to re-evaluate its proposed rules on "substandard care" because they are unfair to physicians, and because they make physicians accountable for the care delivered by others.

In a March 8, 1989 letter to HCFA, ISMS Board Chairman Harold L. Jensen, M.D., said there should be "greater protections for targeted physicians to pursue appeal of adverse initial determinations prior to beneficiary notification of alleged substandard care. Involvement of medical and specialty societies in development of any criteria and modification of the provision holding physicians accountable for care rendered by another physician must also be addressed."

HCFA published the rule January 18, 1989, three years after the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Omnibus Budget Reconciliation Act (OBRA) called for denial of payment for substandard medical care in the Medicare program.

HCFA proposed that an initial determination of "substandard care" be made by a physician specializing in the same field as the one under review. Beneficiary notification would

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(L to R) University of Illinois Hospital, UI Dean Phillip M. Forman, M.D., and Michael Reese Hospital and Medical Center

UI dean's resignation sought

Rush seeks talks before UI/Reese vote

by Kevin O'Brien

AS UNIVERSITY of Illinois medical faculty members provided their first official indication of how they feel about the proposed affiliation with the Michael Reese Hospital and Medical Center, officials of Rush-Presbyterian-St. Luke's Medical Center sought to delay an expected vote by university trustees on both the Reese agreement and the proposed agreements with Cook County Hospital.

At a special meeting on April 5, more than 400 College of Medicine faculty members voted 224-186 to approve a resolution calling upon Phillip M. Forman, M.D., the college's dean, to resign because he "has not fulfilled his responsibilities to the faculty" in his handling of the controversial proposals. There were 17 abstentions.

However, a College of Medicine spokesman called the vote a "victory" for the dean because only 427 of the approximately 3,200 faculty members "turned out to vote." The vote is advisory and not binding on the university administration.

The proposed agreement with Michael Reese would make it the university's primary teaching hospital. The agreements with Cook County Hospital would make the university County's main affiliate, and grants County a long-term lease of the University Hospital.

Well-organized opposition by members of the university's faculty and hospital medical staff, house staff, and community groups has already prevented university trustees from voting on the proposed agreements for three months. Additional hearings on the proposed agreements were scheduled for the board's meeting on April 12, and the trustees had indicated in March their intention to conclude the agreements at their April meeting.

The special faculty meeting was the first regarding the issue called pursuant to College of Medicine bylaws since university president Stanley O. Ikenberry announced the agreement last December. Dean Forman and Michael Reese president Henry L. Nadler, M.D., are generally regarded as the principal architects of the agreements.

Significance of vote disputed

"It's a sad day, like impeaching a president," said Truman O. Anderson, M.D., himself a former

(continued on page 14)

Power of attorney aids care

by Eileen Norris

NOT LONG ago, and with little fanfare, Illinois legislators responded to the controversial right-to-die issue with some drastic changes in the law. Now, by filling out a simple form, any individual has the right to control all aspects of his or her medical treatment in life—and death.

Stories detailing tragic scenarios of comatose patients who had verbally expressed a wish to relatives not to be "maintained," but had placed nothing in writing, were common fodder on the 5 o'clock news—and still are.

One such notable case is that of Sidney Greenspan, an 81-year-old man who has been in a coma for four years. His family is asking the Illinois Supreme Court to allow the withdrawal of a feeding tube so that he can die. The high court has never ruled on whether Illinois law allows artificial feeding to be discontinued at the request of a terminally ill patient or guardian.

(continued on page 12)



Geoffrey A. Bland, M.D., Chairman of the ISMS Medical Legal Council

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New awards measure joy

by Kevin O'Brien

IN 1986, Eva Ferguson, then 62, underwent radiation treatments for vaginal cancer in an Alton, Ill. clinic. She later sued her doctors alleging she never contracted the cancer for which she was treated. Last month, a Madison County jury agreed with her. They awarded $2.3 million, including $1.3 million for the customary "pain and suffering" and $1 million for the not-so-customary "hedonic" damages, or the "lost pleasures of life."

It was the second hedonic damages judgment in recent years in Illinois, and proponents hailed the evolving legal concept. But just as some were predicting eventual acceptance of the concept, word came from the New York State Court of Appeals that two similar verdicts were being overturned.

"It's a social issue that I think is going to be vigorously debated over the next several years," said Chicago economist Stanley V. Smith, who testified in the *Ferguson* case.

The word "hedonic" comes from the Greek word "hedonikos" meaning pleasure. "Hedonic damages," therefore, refers to judgments seeking to compensate victims for the loss of the simple pleasures of life, such as walking on a beach, enjoying a Cubs baseball game, or being the recipient of a surprise birthday party your friends throw for you.

"In an injury case, we have always permitted the jury to include within its award for pain and suffering and disability those items which are being called hedonic damages," said Thomas Crisham, president of the Chicago-based Defense Research Institute and an opponent of the concept. However, the theory's champions contend that the loss of the "simple pleasures of life" is equally egregious, and thus subject to separate compensation.

The Smith model

Smith has developed a model for determining the value of human life that purports to give juries guidelines for assessing appropriate hedonic damages. He starts by determining how much the society pays for various lifesaving devices, such as air bags in automobiles and safety features in airplanes. He then explains the standards the government imposes on industry for those devices and the lifesaving benefits that result from those standards.

He said that this cost-benefit analysis reveals the varying prices that society pays for lifesaving. "And much as we can purchase a steak in some restaurants for one price and steak in other restaurants for other prices, we have some variability as to the amount of money that we spend and the amount of lifesaving that results."

Smith said that the value of some statistically unknown person is routinely in the "several million dollar range." Thus, he said he can give a jury a range of amounts to consider when deciding damages. Smith said he offers a recommendation in specific cases, but that the final decision is up to the jury.

Smith's first significant success was in the federal civil rights case *Sherrod* vs. *Berry* in which the jury concluded that Ronald Sherrod of Rockford was wrongfully killed by a police officer making an arrest. The jury awarded Sherrod's estate $1.6 million of which they said $850,000 was "for the value of his life." The 7th U.S. Circuit Court of Appeals in Chicago initially upheld the judgment, calling Smith's testimony "invaluable" in helping the jury determine the most "accurate" estimate of damages recoverable for the "hedonic value of Ronald's life."



Chicago economist Stanley V. Smith

he·don·ic (hĭ-dŏn′yk) *adj.* 1. Of, pertaining to, or marked by pleasure.

The American Heritage Dictionary of the English Language

However, the precedent value of the case was diminished when the Court subsequently vacated its opinion and remanded the case for retrial on other grounds.

Critics question concept

Among Smith's critics, is defense attorney Thomas Crisham. Crisham would not comment on *Ferguson* because his firm is involved in the appeal, but he calls Smith's model "preposterous" and questions the admissibility of such testimony in personal injury cases.

"The general principle of law in all occasions is that expert testimony is only permitted when it is subject matter beyond the knowledge of the jury," said Crisham. He said expert testimony also requires a scientific basis and that the Smith theory is "I submit, a fake science."

He is equally critical of the method when used in wrongful death cases. He cites a hypothetical case of a man who derived his greatest pleasure from beating his wife. Under the theory, if he is killed, the wife could recover hedonic damages for his loss of the pleasure of beating her every day. "It's far-fetched, perhaps," said Crisham, "but I think it shows how ludicrous the whole thing is."

Crisham distinguishes between wrongful death/personal injury cases and the *Sherrod* case because the latter was not wrongful death. Crisham said the law [U.S. Code, Section 1983] upon which *Sherrod* was tried is a civil rights statute meant to deter violations of people's civil rights, including the right to life. "Therefore, it's not entirely unreasonable to permit a jury to make an award for hedonic damages in a civil rights case that results in the death of an individual," he said.

Still, Crisham disputes the notion that one can be an expert in determining what another human being's life is worth. "The value of the loss of smell to me may amount to nothing, but to you it might be the most important thing in the world," he said. "We look for the jury to determine what is the value to be put on the pain and suffering for this plaintiff, in this case, in this situation."

New York court rules

Whatever happens in *Ferguson,* the New York State Court of Appeals has ruled 5-2 in *McDougald et al.* vs. *Garber et al.* that hedonic damages must be considered part of pain and suffering and not a separate category of damages. The Court, which is the state's highest, also ruled that "cognitive awareness is a prerequisite to recovery for loss of enjoyment of life."

However, according to ISMS general counsel Saul J. Morse, J.D., both the majority and minority opinions are valuable in understanding the legal issues involved. "The opinion in *McDougald* is an excellent explanation of non-economic damages, pain and suffering, and hedonic damages. It discusses when they're appropriate and, to an extent, the limits upon them," said Morse. "And the dissenting opinion is I think of equal importance."

In 1978, Emma McDougald, then 31, underwent a cesarean section in a New York hospital. During surgery, she suffered oxygen deprivation that resulted in severe brain damage leaving her "in a permanent comatose condition." McDougald's husband sued on behalf of his wife. Finding for the plaintiff, the jury awarded $9.65 million which included hedonic damages in the amount of $3.5 million in addition to the $1 million award for pain and suffering.

The trial judge on post-trial motions reduced the entire award to $4.8 million, consolidating the pain and suffering and hedonic damages in a single $2 million award. McDougald's attorneys appealed. The Court of Appeals overturned the judgments, stating that, "Simply put, an award of money damages in such circumstances has no meaning or utility to the injured person."

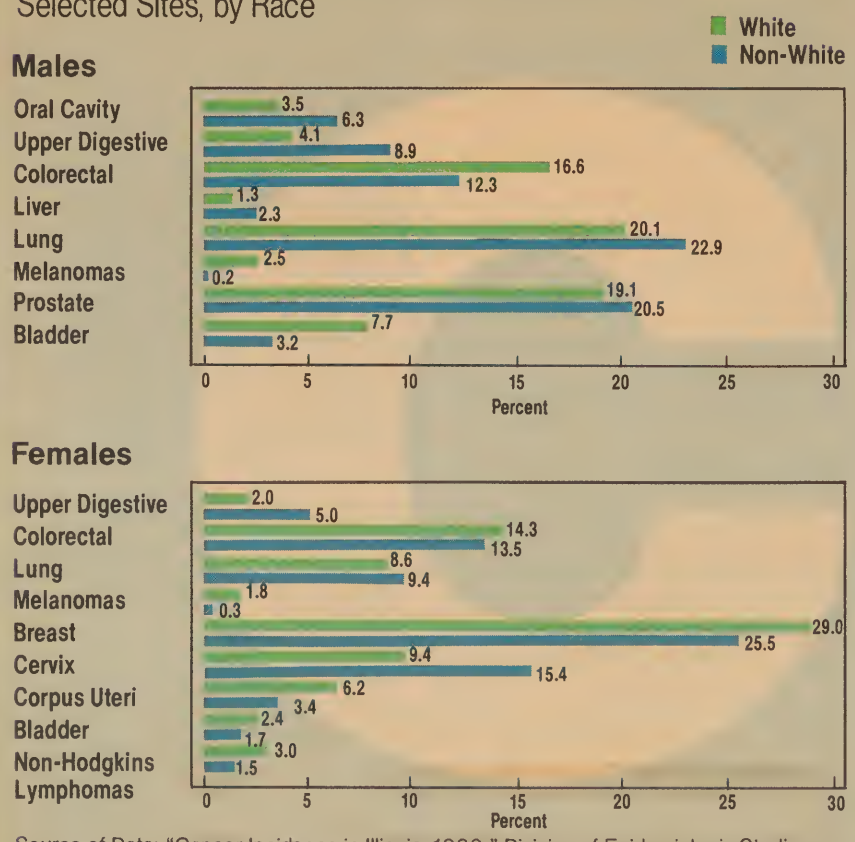
However, dissenting Judge J. Titone said that the lost capacity to enjoy life is at least as serious as physical impairment, which has always enjoyed tort relief. "Indeed, I can imagine no physical loss that is more central to the quality of a tort victim's continuing life than the destruction of the capacity to enjoy that life to the fullest," wrote Titone.

Thus, according to Morse, the legal issues in the hedonic damages debate are slowly being defined. Whether hedonic damages will ever be considered separate from those rendered for traditional pain and suffering, and whether victims will have to demonstrate some level of "cognitive awareness" to collect, will be two of the issues in contention. ▲

Physician Facts

U.S. Congress Proclaims April 16–20 National Minority Cancer Awareness Week

Percentage of Total Cancer Incidence in Illinois for Selected Sites, by Race



Source of Data: "Cancer Incidence in Illinois, 1986," Division of Epidemiologic Studies, Illinois Department of Public Health

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Bylaws guide physicians

by Kevin O'Brien

"MEDICAL STAFF BYLAWS are a bill of rights for the physician," according to Donald W. Aaronson, M.D., J.D.

And according to ISMS general counsel Saul J. Morse, J.D., recent Illinois court cases will increase the importance of medical staff bylaws, not diminish them.

"The courts in this state have consistently held, and especially in the last year or two, that they will not look at the facts underlying a hospital's decision to grant or take away staff privileges," Morse says. "What they will look at, is whether the hospital has complied with its bylaws."

The most recent example occurred on November 30, 1988 when the Illinois First District Appellate Court in *Knapp* vs. *Palos Community Hospital* upheld the concept of "limited judicial review" as it reversed a $400,000 award in favor of three cardiologists who sought reappointment to the hospital.

After the doctors were denied reappointment as a result of peer review, they sued seeking reappointment by the court. The plaintiffs alleged that the hospital and members of the peer review committee violated the staff bylaws when they denied reappointment. The trial court agreed and awarded $400,000 in damages. However, the appeals court found that the trial court had exceeded its jurisdiction and violated the rule of limited judicial review as articulated in past Illinois cases.

In effect, the decision precludes injunctive relief for physicians whose staff privileges have been curtailed or denied if the action is in accord with the procedures specified in the medical staff bylaws. The physician's only recourse is to persuade the court that the bylaws were not followed.

The Illinois Supreme Court rendered a similar decision last May in *Barrows* vs. *Northwestern Memorial Hospital.* In this case, pediatrician William Barrows, M.D., sought appointment to the Northwestern staff as a solo practitioner. When Barrows was denied, he sued alleging anti-trust and fraud. The trial court initially dismissed the suit, saying the staff bylaws were observed, but was reversed by the Appellate Court. The Supreme Court reversed the appellate decision citing the same principle.

Morse points out that while the Illinois Supreme Court action in *Barrows* was not surprising, it was the first time they had reviewed the issue. He notes that the court relied upon provisions in the Medical Practice Act for physicians serving on hospital committees, as well as Hospital Licensing Act protections for staff privilege decisions. Morse adds that last summer's U.S. Supreme Court ruling in *Patrick* vs. *Burget,* is also germane. In *Patrick,* the federal court refused to accept an antitrust argument seeking to reverse what the court considered to be bad faith peer review.

"The two cases taken together seem to stand for the proposition that Illinois courts will not look behind credentialing decisions, but federal courts will not automatically grant an antitrust exemption for these activities," Morse said. "This then means that staff credentials committees must render their decisions in good faith and with an eye towards improving quality patient care in order to have the maximum legal protection available."

Of the myriad rules and regulations that physicians must adhere to in this litigious age, medical staff bylaws could be the least understood, least attended to by the rank-and-file physician, but probably the most important. They, in effect, govern a physician's entire practice in a hospital.

"Staff bylaws govern [the physician] from the instant he walks out of the parking lot into the hospital," says Joseph Tecson, an attorney who deals with medical staff issues. "From that moment, he is under not just the bylaws, but the enforcers of the bylaws, meaning the officers of the medical staff and to a considerable extent the administration of the hospital."

Traditionally written in negotiation with the hospital, staff bylaws codify procedures in such crucial areas as physician credentialing, peer review and quality assurance, risk reduction, and medical staff relations with the hospital administration.

According to the 1988 Accreditation Manual for Hospitals, published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), medical staff bylaws exist to ensure the best possible quality of patient care. They specify the mechanisms for the granting, extension, or withdrawal of clinical privileges. Moreover, they precisely detail "due process" provisions relating to quality assurance and peer review.

The bylaws delineate the relationship between the medical staff and the hospital administration and governing board. They provide mechanisms for effective communication among these entities, especially in institutions with multiple levels of governance and administration. In teaching hospitals, the staff bylaws specify the staff supervisory responsibilities over residents.

Tecson says that staff physicians should know their bylaws because

(continued on page 17)

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

AMBULATORY EKG PROCEDURES

Effective January 1, 1989, ambulatory EKG procedures using HCPCS codes Q0019-Q0026 will be reimbursed based on the "functions" performed, without regard for whether the recording media is a magnetic tape or solid-state "data compression" technique.

It is important to note that, in order to bill for Q0019-Q0022, the actual superimposition scanning process *must be performed.* Likewise, in order to bill for Q0023-Q0026, the full 24-hour miniaturized report *must be printed.* The mere presence of a superimposition or full disclosure feature is not enough. They must be utilized. Such utilization will be monitored through post-payment reviews.

Although the HCPCS code will be the same for tape and solid-state devices, "modifiers" will be required to differentiate between the devices to help track usage and charge data.

The following range of codes and modifiers will be applicable:

Code	Modifier	Description
Q0019-Q0022	QT	Superimposition scanning using a magnetic tape recording
Q0019-Q0022	QD	Superimposition scanning using a digital solid-state recorder (without a magnetic tape)
Q0023-Q0026	QT	Full miniaturized printout using a magnetic tape recording
Q0023-Q0026	QD	Full miniaturized printout using a digital solid-state recorder (without a magnetic tape)

Please note that, while no current equipment specifications exist relative to reimbursement codes, such specifications may be developed in the future which could alter a particular device's applicability to a particular code.

(This report is a service to the physicians of Illinois)
4/14/89

Editorials

Life's pleasures: a new legal battlefield

The courts in Illinois have now added "loss of enjoyment of living" to the expanding array of liability theories, as described in an accompanying story on hedonic damages. The recent $2.3 million award represents a victory for proponents of non-economic damages litigation, and breaks new ground in allowing courts to evaluate quality of life. The new ruling is a subtle expansion from previous awards for pain and suffering, since it assigns a dollar value to past, present and future joys of living which the plaintiff will miss.

This new legal direction has the potential to make juries struggle longer with the emotional arguments, and to produce higher monetary awards. With tort reform laws now making some headway, plaintiffs and their attorneys might also see the new legal avenue as a broader pathway for building up damage verdicts. In fact, hedonic damages could thwart moves already underway in several states, including Illinois, to seek caps for non-economic damages.

Law, like medicine is contantly changing, and the new hedonic liability theory takes its place on the continuum. Patients injured through medical negligence should be fully compensated, but damages must be assessed fairly, based on substantive evidence and objective criteria. Juries need to be factually informed in order to make effective decisions, and society itself must constantly seek fairness and balance for both the plaintiff and the defendant.

Measuring quality with a changing yardstick

The difficulty of arriving at a definition of "quality care" is a major element in Medicare's "substandard care" regulations now under consideration. Judging from ongoing debate among health care professionals, legislators and the public at large, quality evaluation is one of the thorniest issues facing both physicians and patients today. And no wonder. Judging quality and competence is difficult, especially when everyone uses different yardsticks of measurement. Physicians may measure quality of care by the excellence of the technical aspects of the procedures involved and the success of the outcome, while the patient's standard may be set by the subjective, intangible quality of the doctor-patient relationship. Health care payers apply yet other measures—sets of technical criteria whose ability to predict quality care has not yet been proven. Their use of instruments to measure cost effectiveness and appropriate utilization, however, should not be confused with attempts to measure the quality of care of a particular patient.

Until recently, the debate about quality did not usually include those outside the medical profession. Now, sophisticated approaches aided by computer software are increasingly used by health care providers, payers and government to attempt to measure the quality of care from information in data bases. The development of reliable standards and measurements for high quality care requires commitment, active involvement and leadership from physicians, so that we craft a system which benefits and protects patients and their care providers. ▲

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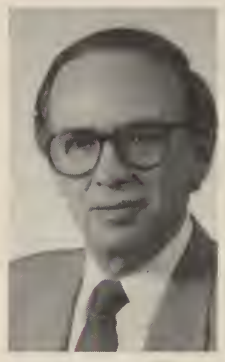
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President's Column

On "apple pie and motherhood"



Harry A. Springer, M.D.

IT'S surprising, but even "apple pie and motherhood" can spark controversy these days, as evidenced by the emergence of public health debates ranging from the safety of the chemical Alar in apples to the stubborn incidence of teenage pregnancy. During my tour of Illinois as your president this year, I learned first hand about the wide array of opinions—both public and physician—on these and other public health issues facing Illinoisans, and reaching well beyond our borders.

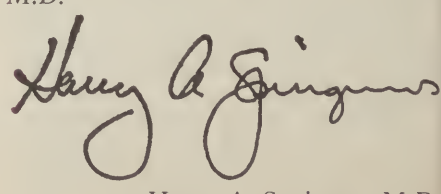
The experience has, indeed, been enlightening. Health care information bombards us and our patients every day from every source imaginable. It shapes opinion and stirs debate. A "health conscious" society laps it up insatiably—and demands more of the same. As physicians, we should welcome the newfound popularity of health information. It usually makes for better informed patients who are taking charge of their own physical and mental well being. But sometimes it also paves the way for spreading misperception and panic. AIDS, a topic that arose frequently during my president's tour presentations, is a good example.

In an age when information is king, what can we do to make sure our message is not drowned out or misconstrued? One solution is obvious, albeit not easy. The health care "information explosion" makes it incumbent upon us—more now than ever before—to share with patients a perspective for evaluating the accuracy and value of information they read in the consumer press, see on television or hear from "experts." By perspective, I mean a basic ability to question the "medical miracles" that offer easy cure for disease and injury; to sift out commercial promotion from consumer information; to evaluate the efficacy of health information; and to extract from the steady information flow a kernel of useful information which can be applied to one's own life, and the motivation to do so.

It's a big job. Many physicians already work to educate patients on a variety of health issues. But we all need to make an extra effort to personalize the messages we give to patients, and to spend time getting them across. Why? Because our competition is working hard to get their message out. Just think how many interests are providing information or taking a stand on health care issues "in the patient's behalf." Businesses, insurers, consumer activists, hospital administrators, drug manufacturers are but a few. This pluralism is beneficial. But physicians must also be strong participants in the debate. We form the front line of providing health care. We can help our patients filter and analyze the vast information available to them on medical issues. We can lend perspective and meaning to the medical information explosion.

Information without perspective does not lead to informed decision-making—either by patients or policy makers in the health care arena. In my view, we must renew our commitment to patient advocacy in the strongest and most personal manner. "Apple pie and motherhood" issues may be lost forever. But as physicians, we must show leadership in the many debates spawned by today's medical information explosion. In fact, we must take on the information explosion, and mold it to build a better health care system for all. ▲

EDITOR'S NOTE: This is Dr. Springer's concluding message as ISMS president. The next issue of Illinois Medicine *will include an inaugural message from incoming president Eugene P. Johnson, M.D.*



Harry A. Springer, M.D.
President
Illinois State Medical Society

Point/Counterpoint

Editor's Note: In light of continuing controversy regarding the proposed affiliation between the University of Illinois and Michael Reese Hospital and Medical Center, Illinois Medicine *recently invited two major participants in the ongoing debate to present their views of the issue by replying to the following inquiry:*

The question: Is the proposed affiliation between the University of Illinois and Michael Reese Hospital and Medical Center a good idea?

An Affirmative View



by Bruce H. Brundage, M.D.
Acting Head, Department of Medicine
University of Illinois College of Medicine, Chicago

THE UNIVERSITY of Illinois has carefully undertaken an affiliation with Michael Reese Hospital and Medical Center as its primary teaching hospital and develop a general affiliation with Cook County Hospital, including the County's long-term use of the U of I Hospital.

These partnerships will give the respective institutions access to the knowledge and expertise of each other's faculties, enhance the education of health sciences students and residents by expanding the scope and diversity of their patient-care experiences and open new opportunities for collaborative research.

Concern has been voiced about the potential impact the affiliation agreements will have on health care delivery to the medically indigent in the Chicago area, namely individuals without any form of health insurance, and those dependent on Medicaid. Obviously, a realignment of relationships among several hospitals cannot alone resolve the problem of care for the uninsured and underinsured. However, the proposed plan will make possible an enhanced University link with Cook County Hospital and full utilization of the University's 10-year-old, high-technology hospital for indigent patients.

Additionally, the University and County are pledged to work together to vigorously attack major public health problems such as AIDS, a high infant mortality rate and the lack of sufficient preventive health resources for the poor.

As University of Illinois College of Medicine Dean Phillip M. Forman, M.D., recently told a group of health providers, health policy analysts, and government, business and community group representatives, the affiliation agreements are proving to be the "catalyst for focusing on problems of providing health care to the medically indigent." To this end, the University has developed a task force to begin planning a national conference on the issue. To be held in Chicago this fall, the program is intended to set a national agenda for improving the health care delivery system and ensuring all citizens access to quality health care, regardless of ability to pay.

The proposed partnerships between the University, County and Michael Reese are neither ill-conceived nor ill-timed. They are rooted in a rapidly changing health care environment that has left many hospitals facing severe financial stress. The impact of that environment has, perhaps, been most significantly felt in Illinois, which has the country's lowest Medicaid reimbursement rate—67 cents to the dollar.

The University of Illinois Hospital has suffered multimillion-dollar losses in three of the last four fiscal years. The accumulated deficit stands at nearly $14 million, and projections indicate it could rise to $70 million within the next five years. "Red ink" of that proportion not only jeopardizes the educational and research programs of the University's College of Medicine, but could bankrupt the University's entire Chicago campus.

Efforts to reverse this budgetary trend have been underway for years with little success. Options have included seeking additional state aid for the hospital; significant cuts in hospital costs through reductions in the number of staffed patient beds, achievement of operating efficiencies and indefinite delays in needed equipment purchases; aggressive patient billing and collecting; and attempts to change the hospital's patient "mix" from one that is nearly three-quarters comprised of Medicaid, Medicare and self-pay patients to one that relies more on patients with commercial health insurance.

Unfortunately, the results of these efforts have been few additional state dollars, a patient population that remains primarily uninsured and underinsured and operation of a half-empty hospital.

This situation provides insufficient clinical experience for residents and students who depend on a large, diverse patient population and weakens the University's ability to serve the health care needs of the surrounding communities and, indeed, the state. Such weakness is exacerbated by an aging Cook County Hospital facility that is inadequate for the needs of the literally hundreds of thousands of Medicaid and indigent patients who reside in the County.

Within the University-Reese-County affiliation plan are the elements for radically improving public health care in Chicago and Cook County and creating what is expected to become one of the nation's premier academic health centers. In addition, the need for more non-hospital, primary care for citizens and for the training of students and residents in Chicago will be fulfilled under the affiliation agreement with the construction of two state-of-the-art ambulatory care centers—one to be built and financed by Michael Reese and one to be erected near Cook County Hospital in the West Side Medical Center District.

In short, three historically excellent institutions are poised, as partners, to take a major health leadership role here. That is a win-win-win situation for Chicago, Cook County and Illinois. ▲

An Opposing View



by John L. Skosey, M.D., Ph.D.
Professor of Medicine,
University of Illinois at Chicago
President, Medical Staff,
University of Illinois Hospital

IF THE UNIVERSITY of Illinois ceases to operate its hospital and requires its clinical faculties to move the main focus of their activities from the West Side Medical Center to Michael Reese Hospital a crisis in medical care will be converted to chaos. The services of 700 faculty, attending physicians and dentists, more than 600 residents and interns, and a large number of other health care workers would be lost to the patient population they now serve.

Over half the patients who account for 15,000 admissions to the hospital, 320,000 outpatient visits, and 45,000 emergency visits each year would end up on the doorstep of Cook County Hospital or another community hospital in the area presently served by the University Hospital. Because these hospitals are already overburdened with indigent patients, the risk of their closing would be increased.

The University of Illinois is a leader in providing perinatal services to a population that has an infant mortality rate equal to that of some Third World countries. If the affiliation with Michael Reese moves forward, infant mortality, which has been reduced by the preeminent perinatal programs at the university hospital, could be expected to increase. Similarly, this patient population looks to the university hospital as its primary source of other specialized services such as transplantation and psychiatric care. A two-tiered system of health care, segregating the poor into already overburdened facilities, would be institutionalized, further decreasing medical service for those most in need.

The University of Illinois Hospital with its associated outpatient clinics serves as an outstanding resource for medical education. Although, in recent years, some universities have separated the financial responsibility for their teaching hospitals from that of the general university, no major medical schools have relinquished control of their university hospitals. Such a move would be unprecedented. Although the University of Illinois for many years has had fruitful affiliations with a number of community hospitals for teaching purposes these arrangements can only complement, not replace, a university hospital as a primary teaching base.

The hospital accumulated debt primarily during years its doors were opened to all individuals regardless of their ability to pay. A major reason now given by the university administration for this proposed affiliation is the alleged poor financial picture of the university hospital. In fact, the university hospital currently is running in the black and is projecting a cash surplus of over $6 million at the end of the current fiscal year.

Further, the hospital management team has projected that with an additional $4 million yearly in-state subsidy or from other sources, the hospital could, over the next five years, pay off its debt and have a surplus. A much needed hospital with a favorable financial outlook would, under the proposed Reese affiliation plan, be abandoned and its resources used instead to shore up the finances of a fiscally troubled private hospital.

Under the proposed agreement, the university would lease, on a long term basis, outpatient facilities to be built and owned by Reese. It would also provide faculty, and help free Reese from the responsibility of providing full-time attending physician salaries. Millions of dollars worth of equipment used by university faculty in clinical practice would be transferred to Reese for the benefit of that hospital. No matter how these funds are laundered, the net result is a movement of state resources from the public to the private sector.

If the Reese affiliation is rejected, as it should be, we cannot be content to simply maintain the status quo. Alternative plans are being proposed to strengthen the West Side Medical Center District through stronger affiliations among the University of Illinois, Cook County Hospital, the Veterans Administration West Side Hospital and Rush-Presbyterian-St. Luke's Medical Center. Any restructuring must take into account the needs of the patient population currently served and the trends in the delivery of health care which are occurring. Rather than building an outpatient facility on the lakefront, the state and the university should be channeling their resources into the development of such a facility on the West Side.

A time of crisis can be made into a time of opportunity. This is such a time. We need to be certain that we take advantage of this opportunity to develop a farsighted, constructive medical future for the people we are obligated to serve. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *What is a companion endorsement?*

A: Policy endorsements are statements added to an individual's basic policy to address individual insurance needs. The endorsement may either restrict or otherwise clarify the coverage being granted in these cases. Because physician employers can be held responsible for their employees' acts or omissions, it is important that restrictive endorsements appearing on an employee's policy also appear on the *employer's* policy. This is the companion endorsement. For example, if an employee has a restriction endorsement excluding coverage for performance of a particular procedure, then a similar endorsement must be attached to the employer's policy. This prevents the employer's policy from responding in the event a claim or suit arises out of the performance of the prohibited procedure by the employee.

Q: *What are the rules regarding suspended coverage?*

A: Current suspended coverage rules apply to physicians whose practices are temporarily interrupted for either voluntary or involuntary reasons. Voluntary interruption of practice may be due to such things as vacation, travel, continuing medical education, or research. Involuntary reasons include incapacitating illness or disability for other health reasons including pregnancy. Requests for suspended coverage for more than one month but less than three months for reasons other than continuing medical education, research or incapacitating illness or disability are not granted. The only option available in these cases is cancellation of the policy. However, suspended coverage requests for more than three months but not exceeding one year receive premium reductions regardless of the reason.

Effective July 1, 1989, however, the rules will be much simpler. Requests for suspended coverage for more than one month but less than one year will be granted whatever the reason. In these cases, the policy will be endorsed and premiums will be reduced to 25 percent of the current premium. However, requests for suspended coverage for less than one month will not be granted, and under no circumstances will suspended coverage be extended for more than one year. Suspended rate reductions will not apply to any other charges used in developing the policy premium such as surcharges or additional insured charges. ▲



Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—Back and neck pain following an auto crash.

Subsequent diagnosis—The treating surgeon determined there were positive indications for surgery for a herniated disc. A consulting neurologist recommended conservative treatment.

The case in brief—A 42-year-old man injured in an automobile accident sought care from an orthopedic surgeon. He complained of pain in the right neck and lumbar area extending to the right buttock. The surgeon admitted him to the hospital that day, ordering traction, pain medication and muscle relaxants. A consulting neurologist recommended conservative treatment with pain medication and muscle relaxants. Nine days later, suspecting that the patient might have a herniated disc, the surgeon ordered a diagnostic myelogram. After viewing the myelogram films, he concluded there were positive indications for surgery. Three days later, the orthopedic surgeon performed a laminectomy without further consultation with the neurologist. He found a stenosing of the dura, but no herniated disc.

The neurologist examined the patient three days postoperatively and, on the basis of his findings, recommended a lumbar puncture to rule out meningitis secondary to bacterial infection or bleeding into the subarachnoid space. He telephoned the orthopedic surgeon, recommending the lumbar puncture, and the surgeon agreed to do the procedure that evening. Upon calling the surgeon later that same evening, the neurologist learned that the surgeon had not done the procedure. The next morning the patient went into

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Case In Point

(continued from page 6)

cardiac and respiratory arrest. The neurologist performed an emergency lumbar puncture and purulent material was obtained. The patient never regained consciousness and died 13 days later. The cause of death was attributed to bacterial meningitis.

The resulting claim—The patient's family filed a wrongful death claim against the orthopedic surgeon, the neurologist, and the hospital, alleging that an unnecessary laminectomy was improperly performed. A further allegation claimed that the surgeon failed to diagnose and treat the ensuing bacterial meningitis.

The outcome of the claim—A settlement was negotiated on behalf of the surgeon. It was discovered that the hospital had known that a hospital-employed assistant to the surgical procedure was a carrier of beta hemolytic streptococcus, group A, so the hospital also contributed to the settlement.

Why problems arose with this case—The two physician specialists did not communicate well about the case in question. Did the neurologist believe the lumbar puncture was urgent? If so, he did not let the orthopedic surgeon know. Or perhaps the orthopedic surgeon failed to take the neurologist's advice to heart. Whatever the reason, the orthopedic surgeon disregarded the neurologist's consulting opinion without confirmatory support. This lapse paved the way for litigation.

The points this case makes—

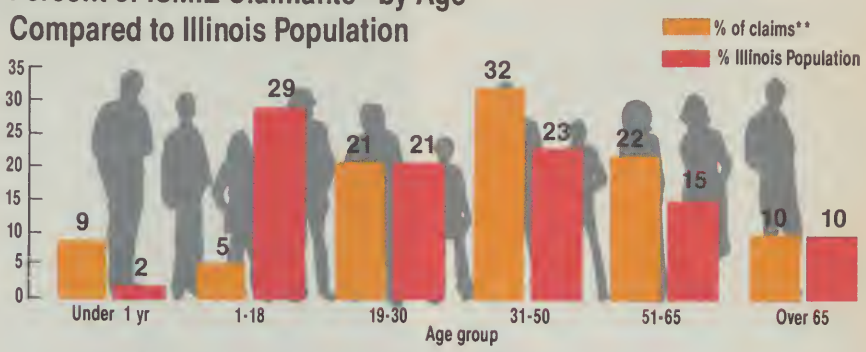
☐ When considering performance of a surgical procedure, it is incumbent upon the surgeon to draw upon the consultative services of other specialists who can help determine whether surgery is indicated and, if so, the specific nature and location of the problem. In this case, failure of the orthopedic surgeon to consult with the neurologist prior to surgery and failure to follow up on the neurologist's recommendation of a lumbar puncture to evaluate postoperative complications, compromised the defensibility of the case.

☐ Personal conflicts should not interfere with sound medical judgment. Why did the surgeon fail to consult with the neurologist in making the decision to operate? Why did the surgeon disregard the repeated recommendation that a lumbar puncture be performed to evaluate the patient's deteriorating condition? Was the neurologist overly aggressive in making his recommendation? Could he have more effectively presented his views to his colleague? The general rule should hold that regardless of the reason for disagreement with diagnosis and treatment recommendations from consulting physicians, the treating physician should give serious consideration to the recommendations of consultants and should seek out such additional consultants or second opinions as may be appropriate.

☐ Disregarding consulting opinions without confirmatory support from colleagues or documentation of reasons for selecting another course that can be evaluated on the basis of sound medical judgment may impact very negatively on your ability to defend yourself if a medical liability claim results.

☐ A hospital should enforce infection-control procedures to protect patients from contagious diseases. A strep carrier in a surgical suite poses serious potential problems. If the orthopedic surgeon knew that the surgical assistant was a carrier, then additional liability could have resulted from failure to take proper precautions to protect the patient from an infectious source. ▲

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Source of Data: Illinois State Medical Inter-Insurance Exchange and 1980 U.S. Census population figures



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Team physicians: good friends on the sidelines

by Janice Rosenberg



Lloyd Blakeman, D.O., with Carl Sandburg High School football player Nick Chio.

THE CHICAGO Bears have one. So do the Bulls. And the Sox and Cubs each have one, too. While no one doubts the need for a team physician at professional sports events, athletes at the high school level more often than not play without one. High school coaches and administrators around Illinois believe that having a team physician on hand makes high school sports safer and more enjoyable for young athletes. They are eager to find doctors who will volunteer their time and services.

Currently in Illinois there is a shortage of high school team physicians. In 1988, H. Bates Noble, M.D., an orthopedist and chairman of the Illinois State Medical Society's Sports Medicine Committee, covered football games for Cary-Grove High School. He attended all the games, both home and away. "At only one game in the season," he reports, "was there a team physician on the other side."

According to Dr. Noble, there are even fewer instances of team physicians covering basketball, track, and wrestling. School athletic directors consider these sports to have lower injury rates, but Dr. Noble does not agree. "We're trying to get the Illinois Department of Public Health to do a study on high school injuries," he says, "to find out just where the injuries occur."

Before signing on as team physicians, doctors need to know what is involved. "A lot of people think that if they get a plaid jacket, then they're a team physician," Dr. Noble says. "They stand on the sidelines, look sagacious, listen in on the coach in the huddle and they think that's what being a team physician is. It's not the case."

In order to treat injuries and illnesses at games, a team physician must be well prepared with supplies and equipment. During the games he covers medical emergencies ranging from broken toenails to broken bones. He decides whether a player needs to rest for a few minutes or whether he needs to be removed from the field on a stretcher and taken to the hospital.

The team physician must make himself known to coaches, administrators, and parents. Good communication with the school trainer, if one is available, is vital. Illinois trainers must meet stringent requirements and register with the state. Their responsibilities include equipment fitting, conditioning programs, and post-injury rehabilitation. While they can handle bruises, cuts and abrasions, they depend on the team physician to take charge in more complex cases.

In treating players, the team physician must be sensitive to the medical patterns already established by the athletes' families. "You don't push yourself between the athlete and his usual care-giver," says Dr. Noble. "You smile bravely if you're an orthopedic surgeon and the kid's family doctor recommends a different one."

While most team physicians are unpaid volunteers, a few receive token payment. In either case, out on the field the team physician has the final say as to whether an athlete is in or out of a game. From the outset he must be sure to establish his authority.

Some physicians who would enjoy working with high school athletes shy away from becoming team physicians because they fear liability problems. "The possibility of being sued is always there," says Robert C. Hamilton, M.D., who serves as team physician for DePaul University and Gordon Technical High School, both in Chicago. "Many times you're called on to treat people from other teams and from the audience."

While Hamilton admits that serving as a team physician increases exposure to liability, he states that a team physician who acts in good faith does not pose a significantly greater risk to an insurance company. Team physicians have always been and continue to be covered by the Illinois State Medical Inter-Insurance Exchange. The insurance company would like to be notified by policyholders who become team physicians, but there is no resulting premium increase.

Dr. Hamilton notes that trainers have their own liability protection, either through the National Athletic Trainers Association or through their individual school boards. He encourages team physicians to work out a written protocol for their school's training. "The duties of the trainer should be well delineated," he says. "There are areas that he can treat under the auspices of the team physician and other areas which he should refer directly to the physician."

Dr. Noble strongly urges team physicians as well as physicians who donate their time at special events like marathons not to take on the title "director." "Being a director," says Dr. Noble, "creates a different level of responsibility. It creates problems in terms of liability. Make sure you're called an advisor or consultant. And remember," he adds, "the case law on team physicians being involved in litigation is real slim."

The Illinois State Medical Society Team Physician Award was created in 1983 to recognize physicians who have had tenure for over ten years as team physicians on the high school and college level. The award is intended to encourage others to become team physicians and to highlight the importance of medical supervision of sports. Anyone—including coaches, school officials, athletes, parents, other physicians, the media and civic organizations—may nominate a team physician for an award.

This year five team physicians were approved for awards by the Illinois State Medical Society Board of Trustees. The presentations were made March 16, 1989, at the Illinois High School Association's (IHSA) Class AA Boys Basketball Tournament in Urbana, Illinois. The IHSA has hosted the presentations since the inception of the awards in 1982.

Meet this year's winners:

Lloyd Blakeman, D.O.

In his twenty-seven years as team physician Dr. Lloyd Blakeman, general practitioner in Worth, Illinois, and team physician for Carl Sandburg High School in Orland Park, has rarely missed a home football game. "I came here to help out be-

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(continued from page 8)

cause this was my home school district," he says. "I like being with the kids."

Dr. Blakeman has a close working relationship with the school's trainer, John Wator. "John and I have stood in some mud together," he says. If a player is injured, doctor and trainer will not allow him to return to the game unless they are absolutely certain that it will cause no further injury. "We have kids and parents all the time who try to push us," the doctor says, "But we have absolute authority. The coaches grant it to us."

Besides attending games, Dr. Blakeman promotes the importance of warm-ups in the prevention of injuries. "Years ago they weren't required," he says. "Now pre-season conditioning and strength training as well as the ten minute warm-up of pushing, lifting, and stretching before the game make a big difference in the number of injuries."

Nevertheless, injuries do occur. During football games the local rescue squad parks its ambulance nearby. Injured players are taken to Palos Community Hospital in what Dr. Blakeman calls "a mobile intensive care unit." "When you play football," he says, "you're going to have people hurt. It's a collision sport. In our district most of the teams have team physicians."

"When a player is injured he's referred back to his family doctor," says Dr. Blakeman. "I do not try to take over the care of somebody who's under the care of another doctor. Maybe that's why I've lasted here so long."

Audley F. Connor, Jr., M.D.

When Chicago internist Dr. Audley F. Connor, Jr., decided to work with high school athletes he involved Jackson Park Hospital in the project, too. "I found out that the Chicago Board of Education doesn't have a



Audley F. Connor, Jr., M.D., Chicago

budget item for athletic trainers or team physicians," he says, "so Jackson Park adopted six high schools in our service area."

Approximately five years ago Dr. Connor called a meeting of the high school athletic directors. "We listened to their problems," he says. "They had some coverage at their games by paramedics from the Chicago Fire Department but that was limited, to say the least."

Dr. Connor initiated his work with the coaches by taking a firm stand to encourage the prevention of sports injuries. "We began by indoctrinating the coaches in the importance of stretching exercises instead of just the usual couple of runs around the field before practice," he says. "This resulted in a significant reduction in injuries."

Next, the hospital began offering physical exams to the athletes. The athletes are seen and examined by residents in the hospital's family center with Dr. Connor or another physician supervising their work. Besides benefiting the schools, this arrangement helps the residents fulfill in part the sports medicine requirement of their family practice curriculum.

Dr. Connor also instituted an Annual Sports Medicine Conference for coaches. Student managers and trainers are also invited to attend. Speakers have included DePaul team physician Dr. Robert Hamilton, Bears team physician Dr. Clarence Fossier, and Northwestern University women's softball coach Sharon Drysdale.

Dr. Connor is proud to say that his program has reduced injuries. "We're further able to reduce them," he adds, "when we give on-the-scene first aid and get the athletes into the hospital system for x-rays and whatever other medical attention they need."

Merle J. Denker, M.D.

After seventeen years as team physician for St. Charles High School in St. Charles, Illinois, Dr. Merle J. Denker describes his involvement with high school athletics as completely natural. "It goes back to when I was participating in athletics in high school," he says. "My father, who was also a physician, took care of the teams. I've always been interested in athletics and athletes."

Dr. Denker's work as a team physician started during his medical training days. "When I was a resident, Dr. Robert Hamilton was taking care of DePaul and a number of Catholic high school football teams. Since he couldn't be in two places at once, I used to do some of those games for him."

When he started practicing orthopedics in St. Charles, Dr. Denker had the opportunity to help with the high school football team. Since signing on he has attended all the home games. "I try to go to the away games, but sometimes my schedule won't allow it," he says. "But if I know that there is not going to be a physician from the other team at an away game, then I definitely go."



Merle J. Denker, M.D., St. Charles

(continued on page 10)

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Team Physicians

(continued from page 9)

In seventeen years Dr. Denker has never been sued in connection with his work as a team physician. "We're all concerned now with liability issues," he notes, "but I don't think that you can walk around looking over your shoulder all the time either."

While he appreciates the help of the St. Charles athletic trainer, on the field Dr. Denker makes the final decisions. "Most of the time any conflicts I have about whether a kid should leave the game are with the athletes themselves," he says. "The entire coaching staff, the administrative staff, the trainers, the parents are all very supportive."

Dr. Denker encourages his colleagues to become high school team physicians. But to be a team physician, he strongly emphasizes, "You have to enjoy being with the kids. That's the best part, sharing their experiences, good or bad."

Theodore Grevas, M.D.

Nostalgia for his days as a high school athlete accounts in part for Dr. Theodore Grevas' years as a team physician. "I came back to my home town to practice," says the Rock Island, Illinois, general and vascular surgeon. "My brother-in-law was the team physician at the time and when he gave it up, I inherited the position."

During his days as a student at Rock Island High, Dr. Grevas played basketball and football, and went out for track, lettering in all three sports.

Dr. Grevas has been Rock Island's



Theodore Grevas, M.D., Rock Island

team physician since 1961. "Today's high school athletes are bigger," he says. "They're more physically capable, better trained, and they're specialized. There aren't as many all around multiple lettered athletes as there were in my day."

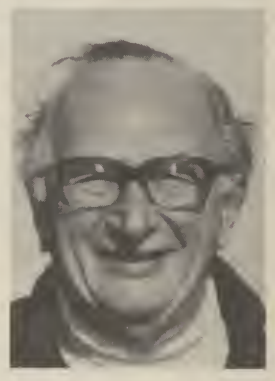
Cooperation from everyone at the high school has been excellent over the years. "Good trainers take the weight off the team physician," he says. "I'm called in for emergencies. About the most serious ones I've seen are a dislocated shoulder and a dislocated elbow."

As far as liability concerns go, Dr. Grevas points out that being a team physician is like doing anything in medicine. "You try to do the best you can and keep on top of new developments. That way liability is minimized."

Watching his own son follow in his footsteps as a Rock Island quarterback added to Dr. Grevas' enjoyment of his role as team physician. Now his dream is to see the Rock Island basketball or football team win a state tournament.

Irwin A. Smith, M.D.

Last fall, after thirty-seven seasons, Dr. Irwin A. Smith retired from his post as team physician for Glenbrook North and South High Schools. "I'm going to miss those days on the football field," he says. "I think the best part of all these years is that when you're with kids you never feel old. I loved being with them and watching them grow up."



Irwin A. Smith, M.D., Northbrook

Dr. Smith, a family practitioner in Northbrook, Illinois, has covered two generations of Glenbrook athletes. "The only thing I didn't enjoy," he continues, "is the weather."

In his years as a team physician, Dr. Smith has seen changes in high school athletics. "Pre-season training is more sophisticated," he notes. "The kids themselves are better motivated, the equipment is more sophisticated, and the control over the physical status of these kids is much tighter."

The last word on whether an athlete can play comes from the doctor. "Many times I've gotten a tremendous amount of pressure from parents," Dr. Smith says. "But I'm not going to put a kid with an injury in jeopardy." For the most part, parents are delighted to know that there is a physician on the field. "And I never had any problems communicating with the coaches, administrators, or trainers," he adds.

While acting as a team physician Dr. Smith did not worry about liability problems. "I was sure ISMIE would cover me," he says. "Fortunately, I've never been sued as a result of an injury."

Dr. Smith points out that in some high schools the team physician gives physicals to all the athletes in a kind of mass production session at the start of the year. "I don't think that's smart," he says, "because you have no background on the kids."

Summing up his years on the field Dr. Smith says, "I loved every minute of it. Sports keeps the kids out of trouble. Busy kids, happy kids." ▲

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

Hypertension: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R(815)

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PUBLIC HEALTH REPORT

By Judy Alsofrom

Measles outbreak

A major measles outbreak on the campus of Bradley University in Peoria is alarming public health officials.

Transmission of cases on the campus started in February and is still occurring, according to the Illinois Department of Public Health (IDPH), with a total of 100 confirmed cases.

Officials are particularly disturbed that students who have contracted the disease were "for the most part" appropriately immunized.

Following recommendations for an outbreak situation issued by the American Commission on Immunization Practices early this year, IDPH informed campus authorities that anyone who received measles immunization prior to 1980 should be revaccinated, if feasible. IDPH will cover the cost ($9.19 per dose) for Bradley students, faculty and staff.

As measles continue to break out on the Peoria campus, there has also been one confirmed spread-case at Illinois State University (ISU) in Normal, and one suspect spread-case at the University of Illinois in Urbana.

Rheumatic fever rise

IDPH also warns physicians that rheumatic fever appears to be on the upswing, noting a modest increase in cases during recent years.

In 1983 no cases of rheumatic fever were reported in Illinois; one was reported in 1984; one reported in 1985; none reported in 1986; four reported in 1987; and nine reported in 1988. "These case numbers will only go up," said an IDPH spokesman. "This could be a trend. In some other states, like Ohio and Utah, public health officials are seeing similar case-number increases and are using the words 'small outbreaks,' " the spokesman said.

The case numbers for 1988 were not confined to the pediatric population—only two-thirds occurred in pediatric patients, and one-third in patients 20 years and older.

IDPH believes the only effective way to prevent rheumatic fever is by treating strep throat. A 10-day regimen of oral penicillin is currently the recommended treatment. This recommendation from IDPH echoes those of the Centers for Disease Control, the American Academy of Pediatrics, and the American Heart Association.

Hepatitis A and Lassa fever

In other alerts, IDPH officials inform physicians that a history of drug use can be consistent with risk factors for hepatitis A exposure. Since late 1986, outbreaks of hepatitis A among intravenous drug users have been identified in upstate New York and northern California, and in December, 1988 in Colorado.

A DuPage County resident who was exposed to and caught Lassa fever in February during a trip to Africa, died March 9.

Lassa fever is a viral hemorrhagic disease limited primarily to the African continent's west coast. It is transmitted by ingestion of food contaminated with the urine of multimammate rats.

Although the exposed man died, no one else in his family caught the disease.

"The moral to the story," according to an IDPH spokesman, "is when a patient reports a history of travel to a developing nation, that part of the history should be taken into account when developing a diagnosis, or at least given cursory consideration on a list of differential diagnoses." ▲

ISMS renews CME accreditation

The Illinois State Medical Society has been resurveyed by the Accreditation Council for Continuing Medical Education (ACCME) and was awarded accreditation for four years as a sponsor of continuing medical education for physicians.

The ACCME rigorously evaluates the overall continuing medical education programs of institutions according to standards adopted by all seven sponsoring organizations of the ACCME. These are: The American Board of Medical Specialties; the American Hospital Association; The American Medical Association; the Association for Hospital Medical Education; the Association of American Medical Colleges; the Council of Medical Specialty Societies; and the Federation of State Medical Boards. ▲

AXID®
nizatidine

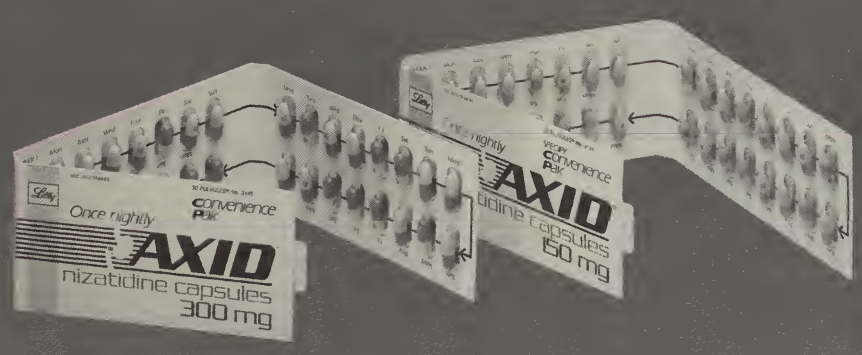
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- 100% said the directions on the Convenience Pak were clear and easy to understand
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Indianapolis, Indiana
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1. Data on file, Lilly Research Laboratories.

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AXID®
nizatidine capsules

Brief Summary
Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.
Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.
3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.
Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.
Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.
Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.
Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.
In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.
Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.
Pediatric Use — Safety and effectiveness in children have not been established.
Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.
Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.
Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.
CNS — Rare cases of reversible mental confusion have been reported.
Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.
Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.
Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.
Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.
Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.
Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.
Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.
If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

(continued from page 1)

Historically, and in cases such as Greenspan's, hospitals and physicians have had their hands tied because they were carrying out their ethical and legal obligation to sustain life. (Apparently, Mr. Greenspan didn't have a living will, which would have at least expressed his desire that heroic or artificial measures not be taken to save him).

"It can be a terrible situation for the family," says Saul Morse of Springfield, general counsel for the Illinois State Medical Society. "And the physician and hospital are stuck in a horrible dilemma as well."

"Physicians have been on the horns of this one for some time," agrees

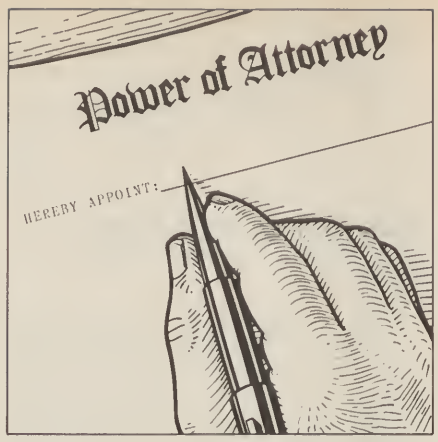


Illustration by Ken Simpson

Karen McKay, a partner and estate planner with the law firm of Burke, Wilson & McIlvaine, Chicago.

But all that is changing. As of September 22, 1987, the legislature expanded Illinois statutes regarding power of attorney. The new law, for the first time, allows the creation of a "power of attorney for health care."

Simply put, it says that individuals have the right to control all aspects of their medical treatment, including the right to decline treatment, or direct that it be withdrawn altogether.

Far reaching power for patients

While Illinois' Living Will Act has been on the books at least four years, offering individuals a way to express their wishes about being kept alive through artificial means, the durable power of attorney for health care is an extension of that theme, but with more far reaching powers.

Not only can patients mandate what life sustaining measures should or shouldn't be taken if their condition is terminal, but they also appoint an "agent" who, in effect, makes all medical treatment decisions for them once they have become incapacitated.

"This legislation was passed in response to all the cases we read about in the newspaper in which the family says, 'This isn't what he wanted. He didn't want to be hooked up to machines in order to live,' " says McKay.

For the power of attorney document to be valid, patients must have named an "agent" to make decisions on their behalf in the event they become incompetent. A total of three successor agents can be listed in the document, but only one agent may act at a time. Patients and their agents must let health care providers know that the durable power of attorney document exists. In turn, the physician is required to consult with the agent when the patient has become incapacitated, and a health care decision is needed.

Once the physician has read a copy of the power of attorney document, he or she should follow the agent's directions. The agent makes decisions about medical treatment, hospitalization, surgery, and the start or withdrawal of life-sustaining measures, autopsy and even organ donations.

Physicians see pros and cons

What is the reaction of Illinois physicians to the new law? "The physicians seem to like the idea because it's a definite, previously thought-out method of dealing with someone's wishes in a positive way," says Morse.

J. Paige Clousson, Chicago, an attorney who represents physicians in legal matters, echoes that opinion. "My guess is that physicians would be relieved to have this piece of legislation as law." But the feeling among some doctors, says Nancy J. Brent, Chicago, a nurse/lawyer in private practice, is that the document is too far-reaching and an infringement on the physician's right to practice medicine.

Morse points out that the law really doesn't change standard practice because the physician has always had to get approval from the patient for certain medical procedures. "The physician can still suggest appropriate medical care, but can only provide it with the permission of the patient or his agent."

"Some will not like the law," concedes Geoffrey A. Bland, M.D., chairman of the ISMS Medical Legal Council. "But I think it's safe to say that the majority of physicians welcome it."

He adds that the durable power of attorney for health care "is a much better document [than the four-year-old Living Will Act] because it is less open to attack from family members. I have many living wills on file in my office, but there's not enough teeth in those documents."

Improving upon the living will

The Living Will Act was also amended by the legislature but the changes were mostly cosmetic. A signed living will says the individual wants life-sustaining procedures withdrawn or withheld in the event of incurable injury, disease or terminal illness.

Illinois physicians should be aware that amendments made to the Living Will Act include expansion of the definition of "death delaying procedures" (formerly called "life sustaining procedures"), and provide that nutrition and hydration not be withdrawn if death would result from starvation or dehydration rather than from an existing terminal condition.

This legislation was passed in response to all the cases we read about in the newspaper in which the family says, "This isn't what he wanted."

The law also now allows a physician to assume in good faith the validity of a living will document and be exempted from criminal or civil liability or consequences of unprofessional conduct.

But in the final analysis, the Living Will Act is superceded by the new power of attorney for health care. Since the power of attorney's named agent deals directly with death-delaying procedures on behalf of the patient, it has the potential to be more far-reaching than the living will, says Dr. Bland.

The new law is clear on spelling out a physician's immunity from prosecution. The statute says that if a physician acts in "good faith and with due-care for the benefit of the patient and in accordance with the agent's decisions," he or she will not be subject to any type of civil or criminal liability or discipline for unprofessional conduct, even if death or injury to the patient occurs.

"It's a wonderful document because it clarifies the issue for all concerned and provides physicians with immunity," adds Adriano S. Olivar, M.D., ISMS trustee consultant to the Medical Legal Council.

Power of attorney poses physician duties

Physicians must know their obligations and responsibilities under the law. Specifically, it's important to note that if a power of attorney for health care exists, that agent has ultimate decision making authority and steps into the patient's shoes, says Morse.

While physicians have no obligation to inform an aged or seriously

(continued on page 13)

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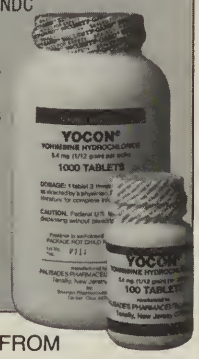
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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(continued from page 12)

ill patient about the power of attorney law, patients should know there is a mechanism to accommodate their wishes. "I believe something like this is reasonable to discuss with an elderly patient," adds Dr. Bland.

According to the law, physicians presented with the document, who find they cannot in good conscience or professional judgment respect the patient's wishes, must see to it that the patient is transferred to another provider chosen by the agent.

Morse recommends any document, whether it be a living will or a durable power of attorney, be put in the patient's medical record. "Physicians should also note the patient's wishes on the chart so that if, for example, a resident at a hospital is providing care, he or she knows the extent of care to be provided," he advises.

Changing decisions: a troublesome area

The power of attorney for health care includes revocation provisions as well. The document may be revoked by being burned, torn or defaced, by a written expression of the appointed agent, or by an oral expression of the patient himself, if a witness signs and dates that communication in writing.

Some physicians familiar with the new law are concerned, says Dr. Bland, that the revocation provisions might hold potential for abuse. "The physician may feel, 'how can I rely on this?' The language of the law says I'm doing it in good faith, but these documents are easy to revoke if someone changes his or her mind," he explains.

That's entirely true, agrees McKay, who believes various points in the law will be challenged in the future.

It's a wonderful document because it clarifies the issue for all concerned and provides physicians with immunity.

"What if a mother signs a power of attorney, naming one of her children as agent, and then gets sick? Another child could say, 'Mother told me she wishes she had never signed that thing and she wanted it torn up.' It's clear this law can be revoked, but what proof will the court require?" asks McKay.

She says it's also possible that the appointed agent who has decision-making power may feel differently about life-sustaining measures than the other children in a family.

Because it's a relatively new law and it hasn't been tested, many attorneys recommend patients sign both a living will and a durable power of attorney for health care.

"While the living will expresses your wishes, it doesn't name an agent to act on your behalf. So I recommend my clients sign both in case one of the documents is lost or legally challenged by other family members," says McKay.

Any potential "gap" is covered by having patients sign both documents, adds David Sterling, an estate and financial planner with the law firm of Ross & Hardies, in Chicago.

"Some people just name one agent, so that if that person dies or becomes disabled, the living will picks up and gives the physician some direction," he explains. "Having both documents gives a clear and clean line of thinking to the physician, regardless of what second thoughts someone in the family might have."

Counsellor Morse agrees that having a carefully worded plan gives the patient the peace of mind to know that his or her wishes will be followed. Dr. Bland reiterates that it is, after all, the patients who matter, and giving them the satisfaction of being involved in decision making and having control over their life and death is vital.

Besides following patients' health-care wishes, the new law presents another plus for those close to a dying relative or friend. "Having a power of attorney takes the decision-making off the family members at a painful time in their lives," says Dr. Bland. "It gives them a clear direction to follow, so that they are not faced with making a decision when they're upset."

Yet another benefit is built-in protections for the physician that haven't been available before, adds David Littman, M.D., an ISMS trustee and consultant to the Medical Legal Council. Dr. Littman, who carries a copy of both the Living Will Act and the Durable Power of Attorney for Health Care in his briefcase, reports being presented with about one document a month from his patients.

There are other indications that the new law is taking hold and that more and more people are hearing about the option.

Don Shaw, President of Hemlock of Illinois, which supports voluntary euthanasia for the terminally ill, received nearly 400 requests for the power of attorney forms after he appeared on a Chicago radio talk show recently. "We couldn't believe the response," he said.

McKay says her clients are delighted to learn they have a choice about how they die.

"I can't think of one person I've worked with in estate planning who hasn't wanted to fill out a power of attorney form," she said.

"I tell clients to give a copy to their physician so that he or she knows they have taken this step. The time to let the physician know about it is when it's signed and not when a crisis arises." ▲

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UI/Reese

(continued from page 1)

dean of the College who nevertheless spoke in favor of the resolution. "But, the faculty felt so disenfranchised that they felt they had to do something."

Although the vote is not binding, University Hospital medical staff president John L. Skosey, M.D., said it has "significant moral force," and that it will be "difficult for the dean to continue to function."

However, College of Medicine spokesman Michael Maggio said the vote was "clearly *not* a mandate for the dean to resign." Citing the low turnout for a meeting that had been planned for more than two months, he said the failure to vote by mail disenfranchised some 2,800 faculty members.

Forman supporters sought to pass motions calling for a mail vote and for the meeting to be held in executive session. Both were defeated. A motion by resolution supporters to vote during the meeting and announce the result before adjourning was approved.

Rush unveils initiative

Meanwhile, Rush officials sought to delay the April 12 trustee vote by sending university trustees a 12-page "discussion paper" outlining parameters of an alternative to the Reese/County agreements.

"We think the trustees as a public body have an obligation to consider other options," Rush vice president for interinstitutional affairs Avery S. Miller said of the Rush initiative.

The Rush paper calls for a renewed commitment to developing the West Side Medical Center District in accordance with original legislative intent, and ensuring quality care to patients "regardless of their financial means." It outlines seven areas of potential cooperation with the university, including a new ambulatory care center, integrated residency programs among all hospitals in the District, expanded nursing education programs, and a "broader collaboration" between the university's College of Medicine and Rush Medical College.

Rush chairman Edgar D. Jannotta, in a letter to UI Board of Trustees president Charles P. Wolff, responded to criticism that the Rush initiative comes too late in the process to be considered. Jannotta said that the first public discussion of the proposed affiliation did not occur until March 6. "The first opportunity we had to react properly as a Board was at our Executive Committee meeting on March 8, two days later," he wrote.

Jannotta also wrote that the Reese/County agreements will "institutionalize or at the least encourage a two-tiered system of health care: one for the insured and the other for the uninsured." In contrast, Jannotta said that a "pluralistic and compassionate approach to health care" would mutually benefit both institutions, and establish a new "synergistic relationship" that would create "an entity for Chicago without rival." Jannotta concluded by saying, "it is our desire to proceed in realizing this potential."

Asked what Rush would do if the university trustees approved the Reese/County agreements on April 12, Miller said that Rush would take its case to the General Assembly which will have final approval of the agreements. ▲

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Substandard care

(continued from page 1)

occur immediately after the Physician Review Organization's (PRO) initial determination. ISMS took strong exception to this early notification. In his letter to HCFA, Dr. Jensen argued that "there can be a legitimate difference of medical opinion between physicians about treatment, procedures, follow-up, etc. Currently, PROs allow physicians to discuss a particular case at various levels of appeal, including access to a committee of specialists, prior to determining that a quality problem exists. The same opportunity must be afforded to physicians with alleged substandard care issues. Any notification to either the hospital or beneficiary that an alleged instance of substandard care occurred should take place only after the physician has had the opportunity to fully exhaust all avenues available within the PRO's appeal mechanism."

The American Medical Association (AMA) raised similar objections in a March 6, 1989, statement to HCFA. During the past several years, many of the PRO's initial adverse quality determinations have been reversed upon review by a second physician, AMA noted. Serious adverse effects on the physician-patient relationship, damage to the physician's reputation, and an increase in the number of unfounded professional liability lawsuits would likely result from prematurely notifying beneficiaries of quality denials, according to AMA.

Thomas R. Hyngstrom, Executive Director of the Crescent Counties Foundation For Medical Care (CCFMC), the Illinois PRO, has assured ISMS in a February 22, 1989, letter that the CCFMC would prefer to withhold patient notification until all formal review proceedings are completed. CCFMC has provided HCFA with comment to this effect.

The comment period on the proposed rules is closed. HCFA will be evaluating all comments received, but there is no specific target date set for publication of final rules. Until rules are final, the PRO will not notify beneficiaries immediately after an initial determination of "substandard care." ▲

Rockford challenges trauma system criteria

by Janice Rosenberg

THE ROCKFORD Council for Affordable Health Care, in its continuing concern over rising health care costs, recently completed a study of the Illinois trauma center legislation and its effect on their community. In February, based on this study, the Council issued a statement.

First, the Council, as a coalition representing insurers, employers, physicians, and hospitals, objects to the Illinois Department of Public Health ruling that any hospital meeting its criteria for designation as a level one trauma center can apply and receive that designation. This rule does not take into account need, geographic distribution, or costs of designation versus benefits. Based on this rule both Rockford Memorial Hospital and St. Anthony Medical Center of Rockford became level one centers. SwedishAmerican Hospital of Rockford is currently a level two center.

"The resulting increase in costs for the community," the statement reads, "for supporting two level one trauma centers, appears to be in excess of $4 million per year. The benefits, according to those in the know—physicians and hospitals—are negligible if any at all. Everyone involved has agreed that two level one trauma centers are not necessary, and, in reality, because of the quality of medicine practiced in the three Rockford hospitals, no level one trauma center may be necessary."

However, if there is to be a level one center, the Council proposes a change in the IDPH rules requiring that a trauma team be on twenty-four hour in-house call. "The in-house requirement is what's causing most of the added expense," according to Winnebago County Medical Society president Robert Bertrand, M.D. Dr. Bertrand has been an emergency physician at SwedishAmerican for eight years and is president of the Winnebago County Medical Society. "The county medical society is introducing a motion at the House of Delegates of ISMS," he continued, "requesting that the IDPH reconsider the rules and regulations to allow some flexibility for hospitals that can guarantee a surgeon being available within fifteen to twenty minutes, to have that count as level one."

Until the rulings can be changed, the Council recommends that all three Rockford hospitals become level two centers. They estimate that this would reduce the cost to the community by $2.5 million per year or $6800 per day.

Due to antitrust regulations, the hospitals are not free to determine among themselves the level of trauma care needed in Rockford or which of the hospitals should deliver that care. The Council called on the hospitals to assess their own situations while keeping in mind the community's best interests.

In response to the Council statement, Gerrie Gustafson, director of community relations at St. Anthony Medical Center, said, "We do agree that the legislation is flawed." While criticizing the Council's suggestion that St. Anthony give up its level one designation as "easier said than done," Ms. Gustafson said, "we stand ready to be one of three level two hospitals."

Rockford Memorial Hospital is ready to participate in discussions aimed at making trauma one status less expensive. One possibility would be to make the staffing requirements less stringent, the hospital suggested, and to allow the trauma team to be activated by emergency care givers while the ambulance is still at the scene of the accident.

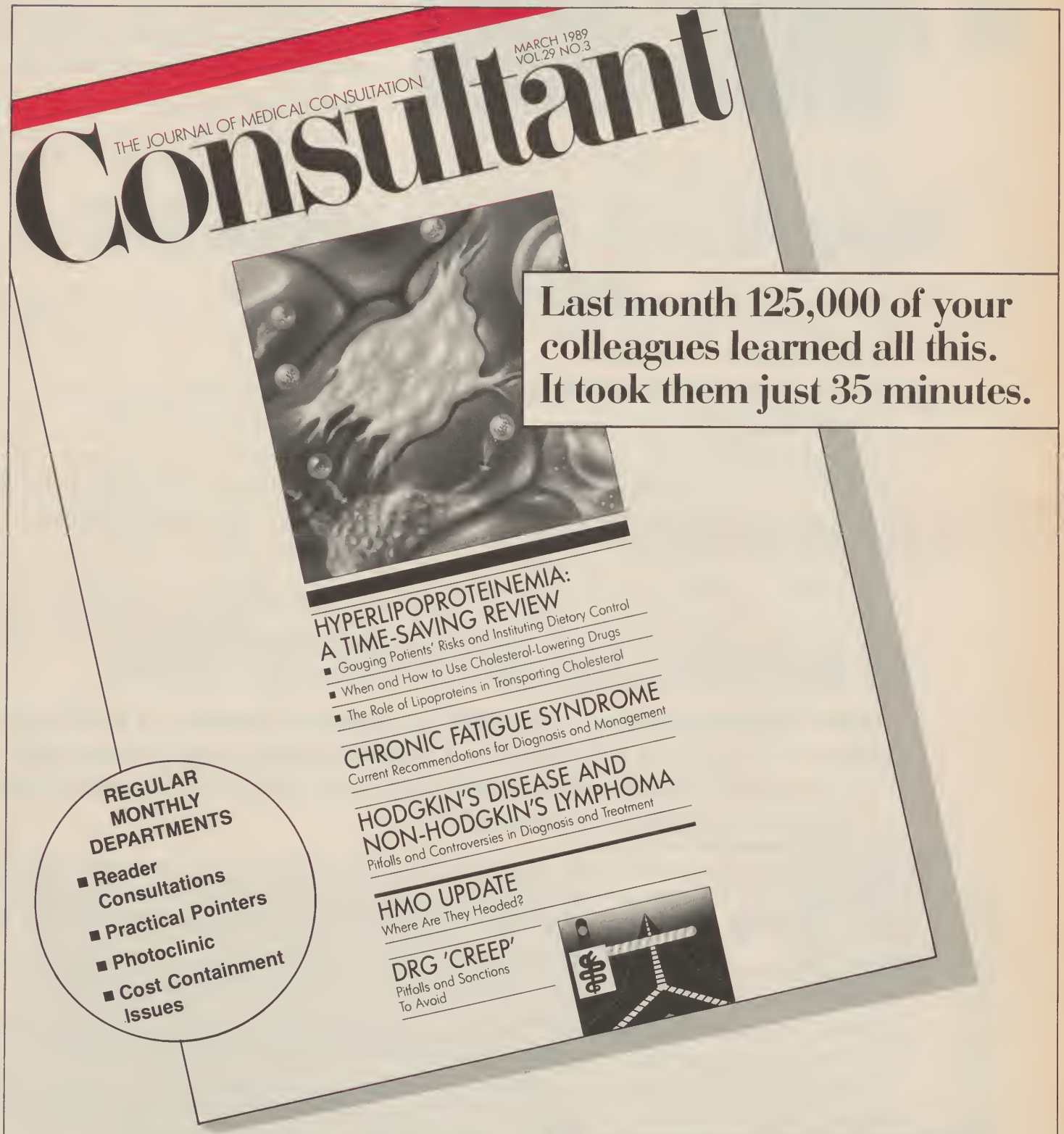
At SwedishAmerican, currently a level two center, Jan Hagenlocher, manager of community and media relations, feels that the trauma system for the state of Illinois was poorly conceived. "We oppose it because it does mandate excessive expenses without adding equivalent value to the care rendered," she said.



SwedishAmerican Hospital, Rockford, a level two trauma center.

Kenneth Robbins, president of the Illinois Hospital Association, agrees with the Council that some of the rules and regulations that the IDPH adopted are unreasonable. "Some of them make it prohibitively expensive for hospitals to be level one centers," he said. "We are working with the Council toward trying to persuade the IDPH to change some of them so that communities like Rockford can have good quality trauma care without having to comply with unnecessarily burdensome regulations."

With the Council representing strong community feelings about the trauma center situation, it remains up to the hospitals and the IDPH to consider possible changes. ▲



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these "are the ones that are the most tightly enforced, because the enforcing mechanisms are right there."

"Bylaws are seldom used to enhance a physician's status or ability to do things," Tecson says. When they are utilized, it is almost always to curtail a physician's activities, whether it be certain clinical procedures or access to certain equipment the physician believes he needs.

Tecson says the reason is that bylaws, like federal, state and local constraints promulgated by public health departments and licensing authorities, are regulatory in nature. On the other hand, the credentialing provisions can protect physicians, especially through their due process procedures.

"Bylaws protect doctors from arbitrary withdrawal of privileges, or the granting of privileges to those who are not entitled to them," Aaronson says.

Hospitals stiffen requirements

Morse points out that as hospitals become more competitive, it will likely become more difficult for physicians to obtain staff privileges because "hospitals will potentially want some loyalty from physicians." In addition, the recently passed federal Health Care Quality Improvement Act of 1986 requires hospitals to recredential physicians every two years.

Of the myriad rules and regulations that physicians must adhere to in this litigious age, medical staff bylaws could be the least understood, least attended to by the rank-and-file physician, but probably the most important.

Morse says that Illinois law provides protection for medical staff members in the form of immunity from liability for peer review activities and credentialing. However, in order to obtain the same immunity under the federal legislation, certain minimum "due process" guidelines must be met. Morse says that hospitals and medical staffs should jointly examine their particular situation, determine if federal jurisdiction applies, and, if warranted, amend their bylaws accordingly. His recommendations are detailed in an ISMS publication "Suggested Changes to Medical Staff Bylaws as a Result of the Health Care Quality Improvement Act of 1986."

The emergence of quality assurance requirements over the past several years illustrates the problems that can arise from the failure to monitor the effect of existing bylaws on day-to-day operations and, when necessary, amend them, Tecson says.

Review devices mandated

These requirements have resulted in a "blanket of review devices" that are mandated not only by medical staff bylaws, but by concurrent rules and regulations on the department level that govern the operation of those departments. Tecson describes a typical scenario: "Perhaps seven or eight years ago, they maybe established a quality assurance committee of the staff; and then maybe a few years after that, a quality assurance committee of the department or division; and the next thing you know, they had to hire someone to coordinate it."

The result is a "patchwork" of regulations—all within the hospital—that has allowed quality assurance enforcement to "get out of hand."

Many authorities believe that the peer review issue, perhaps more than any other, directly affects the current relationship between medical staffs on the one hand, and hospital administrations and governing boards on the other.

On one side are those who believe that the traditional authority of medical staffs as semi-autonomous entities is threatened by hospital administrations encroaching on hitherto sacred ground—policy decisions that directly affect patient care.

One of those most clearly concerned about this perceived trend is AMA-HMSS Chairman Howard M. Lang, M.D. of California. In his report to the AMA-HMSS Assembly in June, Lang said: "It is a time-honored dictate—and plain common sense—that if you are to be held responsible for something, you must have control of it. Our responsibility is to provide quality medical care. We are answerable to our patients, our peers, and the courts for providing that quality medical care. Yet, misguided hospital attorneys will usurp or attempt to usurp the legitimate role of the medical staff."

Hospital administrators and others respond that they too are at increasing malpractice risk. Thus, it is necessary that hospital administrators and their boards take an assertive stance in areas that they heretofore viewed with a laissez-faire attitude. Consequently, hospital administrators are increasingly concerning themselves with credentialing, peer review and risk reduction initiatives.

(continued on page 18)



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(continued from page 17)

Integrated leadership explained

Setting the parameters for reevaluation of the traditional medical staff/hospital administration relationship is the concept of integrated leadership. A proposal of JCAHO president Dennis S. O'Leary, M.D., asserts that hospital care in the 1980s is a complex process that requires the integrated cooperation of physicians, nurses, technicians and other allied health professionals. Proponents of the concept maintain that sustaining a high level of quality care in these complex institutions mandates an unprecedented degree of cooperation among the institution's leadership—medical staff, administrators and governing boards.

The courts in this state have consistently held, and especially in the last year or two, that they will not look at the facts underlying a hospital's decision to grant or take away staff privileges. What they will look at is whether the hospital has complied with its bylaws.

Leadership focus varies

The vehicle for this reevaluation is Dr. O'Leary's "Agenda for Change," a long-term initiative to refocus hospital accreditation measures in clinical and organizational areas. The current accreditation manual addresses institutional leadership issues in several chapters, each focusing on a different component of the leadership mix. Dr. O'Leary, in a recent interview in *Trustee* magazine, indicated he would like to see a different approach.

"Successful hospitals around the country today are those that have done a good job of integrating the functions of the governing body, medical staff, and administration and management," Dr. O'Leary said in the interview. "I think that tells us that if we want to write standards that really relate to the organization's ability to meet quality objectives, we should probably write one chapter—call it Hospital Leadership, perhaps—that talks about the appropriate roles, responsibilities and functions of those three elements and how they work together to get the job done."

ISMS-HMSS Chairman Joseph L. Murphy, M.D., is unconvinced. "The hospital unified leadership concept proposed by the JCAHO dilutes the authority and responsibility of the medical staff, and jeopardizes the medical staff's ability of self-governing which can actually defeat the purpose of quality assurance."

Part of the problem is that integrated leadership is still a concept seeking definition in the real world, which means that one of the main questions will be the relationship of the medical staff bylaws to the corporate bylaws of the institution. Given that doctors are essentially independent contractors who do not work for the hospital, it is difficult to imagine a hospital management structure absent two distinct operational entities.

Checks and balances necessary

Morse believes that a check and balance on both medical staff and the hospital administration is necessary. He advocates viewing medical staff bylaws as a contract between the staff and the hospital, although he does note, the Illinois courts have not yet formally accorded such status to medical staff bylaws. Tecson agrees, but adds that corporate bylaws still legally govern the institution. Therefore, the hospital is probably the ultimate authority in determining what transpires in the institution.

In the days when there were fewer of the "turf" disputes that seem prevalent today, both sets of bylaws coexisted in a fashion reflecting the coexistence of the institutional entities they governed. But that is changing, and much of the conflict that is arising will be manifested in negotiations to amend staff bylaws.

There are periodic reports that some hospital governing boards attempt to unilaterally modify, or even totally rewrite, the medical staff bylaws. Obviously, medical staff resistance to such efforts is strong. One result of this resistance is a 1986 addition to the JCAHO's Accreditation Manual for Hospitals prohibiting either the hospital governing board or the medical staff from "unilaterally amend(ing) the medical staff bylaws."

Tecson does not believe it is fruitful for hospital boards to write the medical staffs' bylaws for them. "I think that where that has happened or [been] attempted, it results in such chaos that I don't think it's been effective."

Consequently, continuing good faith negotiation of medical staff bylaws by both still seems to be one of the best ways to improve the working relationship between medical staffs and hospital administrators and governing boards.

"I think we need to be aware of the fact that interests at times don't coincide," Morse says, "and until we're really comfortable with how to deal with that, I think we need to look at integrated leadership as a goal more than as a reality." ▲

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April 28, 1989 ILLINOIS STATE MEDICAL SOCIETY



Eugene P. Johnson, M.D., is sworn in as 1989-90 ISMS president by Harry A. Springer, M.D., outgoing president.

ANNUAL MEETING 1989

ISMS delegates vote on key health issues

Delegates to the annual meeting of the Illinois State Medical Society's House of Delegates debated a broad range of policy issues. The House of Delegates convened April 6-9 at the Westin O'Hare in Rosemont, Illinois. Some of the major issues discussed and voted upon at the meeting include:

Health care financing

Peer Review Organizations (PROs), public education on the shortcomings of Canadian and British health care delivery systems, and questionable telephone practices of external review organizations were among 14 health care financing resolutions occupying the attention of the ISMS House of Delegates at the annual meeting.

The reference committee heard testimony on a resolution opposing a "draconian" Medicare regulation requiring PROs to notify patients of "sub-standard care" findings. Although the resolution was directed at the Crescent Counties Foundation

(continued on page 8)

Lawmakers view award caps again

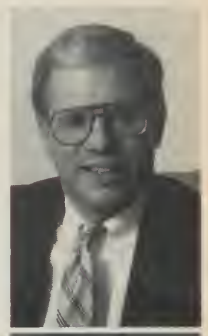
LEGISLATION to cap non-economic damage awards in medical malpractice cases is again before Illinois lawmakers for consideration. Introduced in both houses of the General Assembly on Friday, April 7, 1989, the bill would place a $250,000 limit on pain and suffering and other nonmeasurable damages.

The House and Senate Judiciary Committees will be the legislation's first stop. Those panels will hear testimony, and decide whether or not to recommend adoption to their parent bodies. Neither committee has looked kindly upon capping non-economic damages in years past. In 1987, the bills failed to clear either committee, which essentially killed the caps measure. While committee membership has changed slightly in the intervening years, legislative experts again expect a tough battle to release the bills from committee bottlenecks.

State Representatives Alfred Ronan (D-Chicago) and Thomas Ryder (R-Jerseyville) are sponsoring the House version, (H.B. 2164). In the Senate, Robert Kustra (R-Glenview) is chief sponsor of the legislation (S.B. 1272).

"The Illinois State Medical Society remains firmly committed to capping non-economic damage awards," said ISMS president Eugene P. Johnson, M.D., upon introduction of the legislation. "While we firmly believe that injured patients should be fully compensated for all economic losses, capping *non*-economic awards is essential to restoring fairness in Illinois' medical malpractice system."

A strong coalition, including the Illinois Trial Lawyers Association and the Coalition for Consumer Rights, is expected again to line up against the caps proposal. ▲







Bill sponsors (from top): State Senator Robert Kustra (G-Glenview); Rep. Al Ronan (D-Chicago), and Rep. Thomas Ryder (R-Jerseyville).

Mandatory assignment, AIDS, smoking bills advance

by Caryl Carstens

MANDATORY assignment, AIDS and anti-smoking bills cleared major hurdles in Springfield last week.

Legislation requiring Illinois physicians to accept assignment of Medicare charges passed out of the House Consumer Protection Committee April 18 by a partisan vote of 11-5. Ten votes were needed to release it. The Committee action sends the bill to the House floor where it will be on second reading (the amendment stage) this week.

The sponsor, Rep. John McNamara (D-Oak Lawn), presented witnesses from the Illinois State Council of Senior Citizens Organizations.

Eugene Johnson, M.D., ISMS president, was the only witness formally testifying in opposition to the bill. While not presenting testimony, the Illinois chapter of the American Association of Retired Persons and a variety of other medical groups filed notice of their opposition to mandatory assignment.

Dr. Johnson challenged the council's assertion that any charge over the "Medicare reasonable charge" is an overcharge, saying the federal law specifically allows larger charges within defined maximum limits. "Mandatory assignment of every charge would remove the federally permitted and regulated option to accept assignment on a case-by-case basis," he said.

In Illinois, 41 percent of physicians accept assignment—Medicare's "reasonable charge"—in all cases as payment in full. However, on a case-by-case basis, physicians accept assignment on 68 percent of the Medicare cases they handle, according to statistics supplied by Illinois' Medicare program.

Dr. Johnson warned that access to care might diminish for Medicare

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Feds mandate preadmission OK for selected Medicare elective procedures

PHYSICIANS SCHEDULING certain "elective" procedures for their Medicare patients must obtain preadmission certification, according to new Health Care Financing Administration (HCFA) regulations which took effect April 1, 1989. Ten procedures in Illinois' Medicare program are subject to the new requirement—whether done as inpatient or outpatient surgery. If undertaken on an emergency basis, however, the procedure could receive a certification number after its completion, but prior to Medicare billing.

The preadmission okay is aimed at determining the "medical necessity and quality of services," according to a document released by the Crescent Counties Foundation for Medical Care (CCFMC), the Illinois peer review organization (PRO). PROs across the country are required by HCFA to implement the new regulations, and make decisions about which procedures are covered by the precertification program. The PRO will also review the appropriateness of the setting in which the procedure is carried out. CCFMC will issue certification numbers prior to a patient's admission for elective procedures.

The new Medicare requirement stemmed from federal legislation approved three years ago to study the wide variation in utilization rates for certain procedures around the country. "Not only are these some of the most frequent and costly procedures for Medicare patients," explained CCFMC Director Tom Hyngstrom, "some of them also deal with life threatening situations. That's why we're concerned with the appropriateness of the procedures."

Hyngstrom denied that Medicare's intent is to preempt medical judgment or to standardize treatment for these surgeries. "We just want to assure that the wide variation is indeed justified," he asserted. In fact, he claimed that Medicare may find problems of underutilization as well as overutilization once CCFMC collects and examines the preadmission certification data. "The issue is quality and necessity," he emphasized, "and until we do chart review and develop useful data, we're not going to be able to comment."

According to CCFMC, the time at which the certification number is obtained has absolutely no bearing on the approval or denial of care. Failing to request a certification number could, however, delay payment on the case. Whenever a case fails the initial screening, a physician reviewer in the same specialty as the procedure in question will discuss the case with the physician before the denial decision is made.

Illinois physician organizations—including the state medical society's Council on Economics and various specialty societies—provided input to CCFMC on the structure of actual screening mechanisms for precertifying admissions. "The PRO has incorporated our comments, as well as those of the specialty societies," said ISMS Council on Economics Chairman Alfred J. Kiessel, M.D. Dr. Kiessel believes the screening criteria are "generally fair," but that the whole screening process "will require a shakedown period so that the reviewers use [the screens] appropriately."

While Dr. Kiessel concurs with Hyngstrom's assessment that the preadmission certification program was not initially designed to standardize care, he does voice reservations that "the whole process will ultimately serve as a cost containment mechanism. The decision on whether or not one of these ten services is medically necessary can be a very fine line," he cautioned, "and ISMS will be monitoring the process very closely to assure evenhandedness."

To obtain preadmission certification in a timely fashion and avoid admissions delays, "physicians can call in, write in, use the fax," explained Hyngstrom. "After doing over 3000 reviews on the phone during the first weeks of the program, to our knowledge not a single procedure has been delayed." Hyngstrom said that the goal is to return certification codes to the physician on the same day the calls requesting them come in. ▲

Medicare targets ten procedures

The ten "elective" procedures subject to Medicare's new preadmission certification requirement are:

- Cholecystectomy
- Carotid Endarterectomy
- Major Joint Replacement
- Coronary Artery Bypass with Graft
- Percutaneous Transluminal Coronary Angioplasty
- Laminectomy
- Complex Peripheral Revascularization
- Hysterectomy
- Prostatectomy
- Cataract

HCFA defines "elective" procedures as those which can be scheduled. The PRO will conduct its review on a post procedure/prepayment basis for urgent/emergent procedures. ▲

UI Trustees approve affiliations and ask for IDPH study compliance

by Kevin O'Brien

AFTER THREE grueling months of debate, the University of Illinois Board of Trustees on April 13 approved 8-1 the controversial affiliation agreements with Michael Reese Hospital and Medical Center and Cook County Hospital. The board also authorized execution of the county's lease of the university's hospital.

In addition, the board passed a supplementary resolution that instructs the university administration to plan for the "fulfillment of the conditions set forth" in the recently released Illinois Department of Public Health (IDPH) impact study.

Before the vote, university president Stanley O. Ikenberry urged the trustees to approve the three agreements as a package. He warned that failure to do so would result in a "status-quo vision of the future defined through the framework of the past."

"We recommend this action not as a conclusion, but . . . as a beginning," Ikenberry said. "It is the beginning of a better future for health care in Chicago, and it is a beginning for a stronger and better future for the university's academic programs."

The agreement with Michael Reese makes it the university's primary teaching hospital and provides for the construction of an ambulatory care center at Reese that the university will lease. The agreements with Cook County Hospital make the university County's primary affiliate, and allows County to assume management responsibility of the eight-year-old, 500-bed university hospital.

The package must now be approved by the Cook County Board of Commissioners and requires final implementing legislation by the General Assembly. The trustees were told that many legislators, including all members of the Black Caucus, requested that the vote again be deferred. The board postponed an expected vote in March because of stiff opposition from some university College of Medicine faculty, community groups and legislators.

The vote followed almost three hours of additional hearings on the agreements. Chicago Democrat Gloria Jackson Bacon, M.D., was the lone dissenter, as she was in January when the Board voted to approve the agreements "in principle."

"Three months have passed since that time and I am not persuaded any differently as to the merits of the proposal," said Dr. Bacon. "I sincerely believe that this plan represents the sanctioning of an institutionalized two-tier system of health care."

IDPH conditions crucial

At the request of board president Charles P. Wolff, an Elgin Democrat, the board directed that implementation of the agreements incorporate 11 recommendations of IDPH director Bernard Turnock, M.D., contained in the IDPH study of the impact of the agreements on Chicago's health care delivery system.

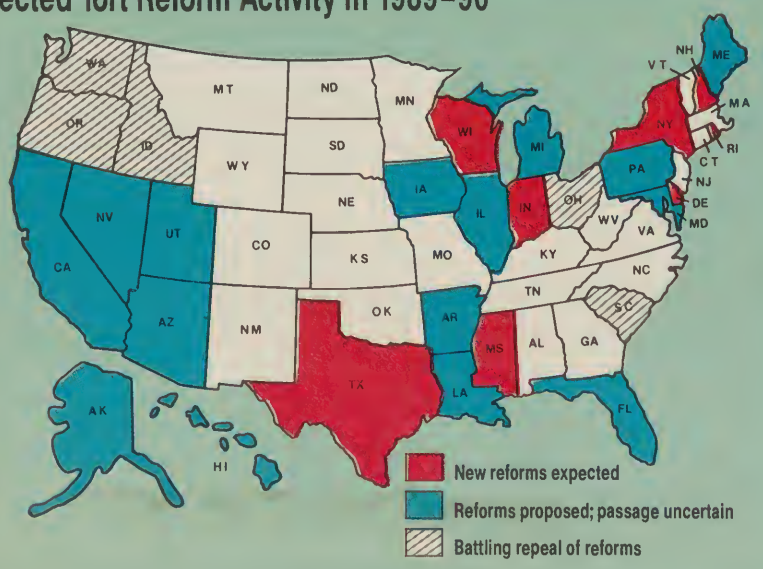
"I am deadly serious as one member of this board," Wolff told the trustees, "that all of those people responsible for planning and implementing these affiliations live up to the intent and spirit of the 11 points made in the Turnock study."

Ikenberry asked Dr. Turnock to conduct the study in response to a request from a senate committee that held March hearings on the agreements. The study, released on April 7, concluded that implementing the agreements need not adversely affect access to health care for the medically indigent provided certain conditions were met.

(continued on page 19)

Physician Facts

Expected Tort Reform Activity in 1989–90*



*Includes but is not limited to medical malpractice reforms.
Source of data: American Tort Reform Association

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Bills advance

(continued from page 1)

patients, much as it has for Medicaid patients. He also suggested there would be a shift of costs to other patients if assignment becomes mandatory.

Clean Indoor Air Act

Anti-smoking legislation supported by the Illinois State Medical Society cleared the House Executive Committee April 12 and was sent to the House floor.

"ISMS strongly supports the passage of a Clean Indoor Air Act for Illinois," President Eugene P. Johnson told the committee. "Physicians have recognized for years that smoking is a proven major health hazard, not only for the smoker, but for those who have no choice but to breathe 'second-hand' smoke."

ISMS has backed similar legislation in previous sessions, but none of the bills has been successful. However, the current proposal, sponsored by Rep. Robert Terzich, (D-Chicago), is co-sponsored by 45 other House members, meaning that only 14 more votes are needed for passage in the House.

The bill would ban smoking, except in designated areas, in such public places as hospitals, restaurants, retail stores, offices, theaters, auditoriums, and meeting rooms. The ban would not cover hotel rooms, taverns, individuals' enclosed offices, factories and warehouses.

The House already has banned smoking in its own meeting chamber and committee rooms.

A rival bill dealing with smoking was approved by the Senate Executive Committee last week. Critics claimed it was supported by the pro-tobacco lobby and prohibited smoking only in areas already put off-limits by municipal ordinances and voluntary policies.

AIDS: premarital testing and written consent

In other legislative action affecting physicians, three bills revoking or allowing suspension of the mandatory AIDS premarital test law have been voted out of committees and sent to the House and Senate floors. ISMS strongly supports repeal of mandatory premarital AIDS testing.

Last week, the Senate Judiciary Committee approved Senate Bill 43, which would rescind the law. On April 18, the House Judiciary I Committee approved House Bill 18, which would abolish required testing for both AIDS and syphilis.

H.B. 36, empowering the director of the Department of Public Health to suspend the tests, also was approved.

Also emerging from the Senate Public Health, Welfare and Corrections Committee by a 5-4 margin was S.B. 166, reinstating mandated written informed consent for AIDS testing. State Senator Judy Barr Topinka (R-Berwyn), who voted in favor of the bill, has asked for amendments to waive written informed consent in emergency situations.

Illinois' written informed consent law had been repealed last year, allowing physicians to conduct HIV tests without written consent "when such treatment is medically indicated," and patients had already given general consent for treatment. ISMS supported the repeal. ▲

Legislative floodgates open

In the General Assembly's first four months, almost 4300 bills have been dropped in the hopper for Illinois lawmakers' consideration. Of those, ISMS is following the 905 determined so far to be health care-related. This compares with a previous *two-year* total of 6600 bills introduced during 1987-88, some 1400 of which were health-related.

ISMS had outstanding success in upholding its policy positions in last year's legislative arena. ISMS lobbyists credit this record to the strong grass roots support of the Society's 18,000 members. However, due to this year's significantly-increased volume of bills, this record will be difficult to match. ▲

ANSWER THIS CALL TO ACTION!

Contact your state legislative representative TODAY to voice opposition to H.B. 402 on MANDATORY MEDICARE ASSIGNMENT.

If you don't know your legislator, or how to contact him or her, ISMS can help.
Call 312-782-1654 or
1-800-782-ISMS. ▲

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

BCBSI INSURANCE CARD GUIDE
PHYSICIAN PREFERRED PROVIDER OPTION (PPO)

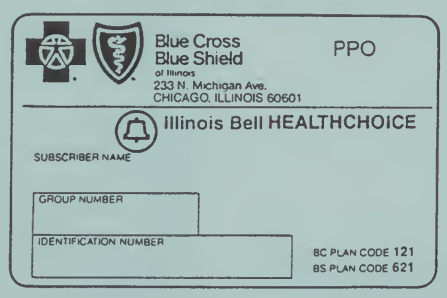
The Physician PPO program is designed to assure the eligible Blue Cross and Blue Shield of Illinois (BCBSI) subscriber a predetermined level of reimbursement, in accordance with the insured's PPO contract and the PPO maximum level of allowances. There are over six thousand (6,000) participating PPO Illinois physicians to date.

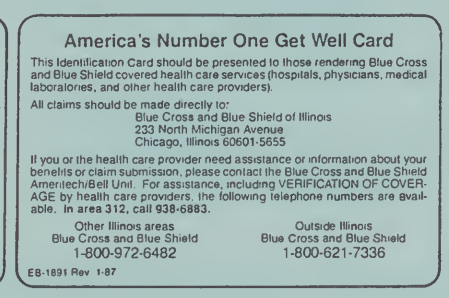
The highlights of the Physician PPO agreement are:

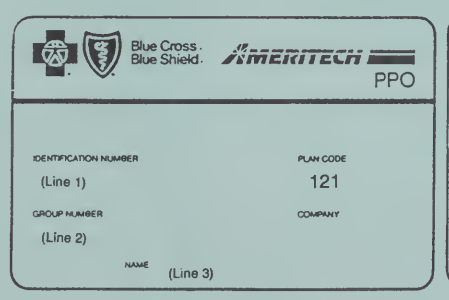
- Physicians are paid directly for covered services. The amount of payment is based on the physician's fee, not to exceed the maximum PPO allowance. Payment is reduced by any deductible or co-payment amount for which the subscriber is responsible.
- Physicians agree not to bill the subscriber for any service that is covered under the subscriber's PPO program. However, physicians may bill the subscriber for services that are not covered under the PPO contract and for any deductible or copayment amount for which the subscriber is responsible.
- Physicians agree not to hold BCBSI or the BCBSI-PPO subscriber responsible for medical/surgical fees associated with any portion of an inpatient hospital stay that is determined by utilization review and/or BCBSI's Medical Services Advisory program to be not medically necessary.
- BCBSI agrees to actively encourage its members to obtain medical services from PPO physicians and PPO hospitals and provides PPO physicians with updated listings of PPO hospitals and Preferred Participating Physicians to assist the referral of eligible BCBSI subscribers to participating providers.

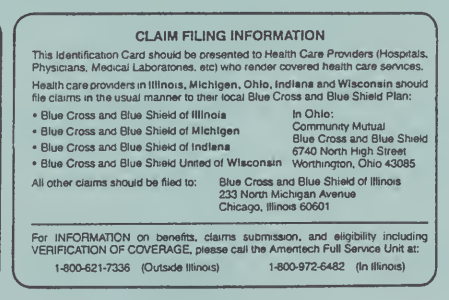
Illinois Bell Telephone Company and Ameritech have selected the BCBSI Physician Preferred Provider Option in addition to the Hospital Preferred Provider Option. The Comprehensive Major Medical benefit program has a $150.00 individual deductible and a $300.00 family deductible per calendar year. In order for subscribers to receive maximum benefit levels, both hospital and medical/surgical services must be rendered by a participating Hospital/Physician PPO provider. Illinois Bell employees Medical Services Advisory Service is "MED-CALL"; general information and phone numbers are quoted on the four-sided paper card. In order to reach a "MED-CALL" advisor, call **1-800-621-0965** (in Illinois) or **1-800-423-7666** (outside Illinois).

Below are samples of the Illinois Bell and Ameritech subscriber cards. Illinois Bell Telephone Company has approximately 40,000 active and retired employees. Ameritech has approximately 3,000 employees located in Illinois. The Ameritech card is plastic. Line 1 = Insured's Social Security number. Line 2 = The Group number and the specific company name and the insured is employed by. Line 3 = Insured's name.









In the May Issue of the "Blue Cross and Blue Shield Report to Illinois Physicians," the new PPO Plus Program will be featured. Initially, this Physician Benefit Program is being marketed in the Chicago Metropolitan area.

(This report is a service to the physicians of Illinois)
4/28/89

Editorials

For a strong anti-smoking law: Bring on the medical muscle

Actions speak louder than words. That's the short reason why Illinois hospitals should ban smoking on their premises. And while the Illinois State Medical Society some time ago had established policy to that effect, the 300 plus physician delegates who attended this year's annual policy meeting thought the issue important enough to reiterate and strengthen that policy. As approved, the resolution mandates the Illinois State Medical Society to "strongly urge that all accredited hospitals in Illinois establish a non-smoking policy for their hospitals, including a complete ban on smoking in patient care areas." At first blush, it seems inconceivable that hospitals would allow at all for such blatantly unhealthy activity, but habits are hard to break—and societal customs change slowly—even in the public health arena.

In this *Illinois Medicine,* you'll also find a story about the proposed Clean Indoor Air Act before the legislature for debate. The measure has gained strength and will hopefully be enacted later this spring.

As physicians, we know that smoking is a major contributor to morbidity and mortality. It's dangerous not only to the smoker, but to those who must inhale the second-hand smoke. In fact, the experts say that smoking related illness kills some 400,000 people each year. These medical facts offer a sound rationale for making hospitals—and other public places—smoke-free. But what can we, as physicians, do to prod the scattered activity, and often-slow pace of decision makers on this issue?

We, the 17,000 physician members of the Illinois State Medical Society, are the voice of medicine in Illinois. As members of our hospital medical staffs, we can and should exert medical muscle to make hospital administrators pay attention to our recommendation for smoke-free patient care. As constituents in our communities, we can and should speak out loudly and clearly for passage of the Clean Indoor Air Act. Patient advocacy in its strongest sense demands no less of us. ▲

Non-economic damage caps: attainable, but not yet achieved

The story in this issue about Illinois physicians' continuing attempts to legislate caps for non-economic damages makes the indelible point that our state's medical malpractice compensation system still lacks stability and fairness. Consumer coalitions and trial attorneys have put the medical profession on notice that they are determined to mount strong opposition to non-economic damage caps, just as they did when consideration of other tort reforms came to the table in 1985 and 1987. They are saying now, as they did then, that there is no problem. But, it's ironic that they now credit 1985 reforms with solving a problem that then supposedly didn't exist.

Malpractice insurance costs remain one of the largest business expenses for physicians. Its impact is felt in higher costs borne by patients and in defensive medical practice to avoid lawsuits. We reaffirm a commitment to fair and full compensation for all economic losses for patients injured through medical negligence. But, without reliable standards to guide them, a jury's assessment for non-economic losses cannot be fair. Achieving non-economic damage caps is going to be difficult, but it's a battle worth fighting, if fairness and balance are to be found in Illinois courts. ▲

Illinois Medicine

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President's Column

The "good old days" aren't gone!



Eugene P. Johnson, M.D.

This column is excerpted from Dr. Johnson's inaugural speech at the ISMS House of Delegates meeting, April 9, 1989.

I'm a small town, rural physician, semi-retired from practice. Life in general moves more slowly in Casey. But medicine—the issues confronting us, our patients and this United States of America—has and does move just as rapidly there as here.

Are the good old days of medicine—with glorious victories over disease and poor health—gone forever . . . as we hear so many physicians say? My answer is, no, they need not be. Together, united, the physicians of Illinois and of this country can make the future of the practice of medicine bright and rewarding, both for us and for our patients.

We all know our health system hasn't been perfect. But we also know that it did produce great miracles, ones copied by countries all over the globe, and attracting people from all over the world to come here for treatment.

Yet, a short time ago, I ran across a headline—a story receiving national debate and attention—that reflects an alarming public disillusionment with our health care system. It cited a poll showing that 89 percent of Americans believe our health care system needs fundamental change. Only ten percent said it functioned pretty well. These results contrasted starkly with opinions of Canadians and Britons, who generally believe their nationalized health systems work well and should stay in place.

I believe this disillusionment to be the result of several converging factors: the huge costs of new technology, the swift-moving advances in medicine, the accepted belief that all of our citizens have the right to health care—which our politicians have equated to a "Cadillac" type of health service rather than the affordable "Ford" or "Chevy," as well as the hodgepodge systems others have created—Medicaid, Medicare, DRGs, MAACs, etc.

Solutions to our quandary prompt urgent and united action, and leadership by us. We know the problems, the pitfalls, and are the best equipped by education, experience and training to supply the answers.

Our message must be unified, must be constructive. We must stop just reacting to solutions of others. We must react to problems by proposing solutions and letting others react to our solutions.

Let's talk first about organized medicine—and how we build our own strength and leadership potential *from within.* It has never been more important than now that medicine speak with one voice. And I firmly believe that the Illinois State Medical Society here in Illinois—and the AMA nationally—are the only organizations able to adequately represent us in that way.

The nearer we can come to 100 percent membership—*and participation*—the stronger will be our public and legislative voice. And the better able we will be to infuse our strength of commitment and backbone into the AMA. Our leadership there is strong, but we can make it even stronger, and spread our message to other state associations.

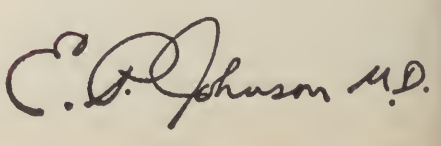
A second challenge is community leadership. This field is indeed broad—encompassing liaison with public policy makers, philanthropic organizations, community networks, media, the public at large and the politicians and government. Why, with so little time for ourselves, should we also be asked to make this commitment?

The reason is simple: planned health care is no longer merely on the horizon. It is here. And planners are in many instances the nonmedical people I spoke of a moment ago. No longer can the physician depend on his medical expertise to carry the day. We must build bridges, and by that I mean long term understanding and respect for our views with the folks we encounter each and every day, our patients, nurses, hospital administrators, and our social contacts.

And we must speak out to business representatives as well, to make them understand that we are professionals who really know about health care and its problems today. They should carefully consider our viewpoint as together we look down the road to future policy issues on patient care.

In short, we must work to lead society's discussion on a variety of critical health care issues. From right-to-die and medical research to peer review and health care finance, it is incumbent upon us to speak our collective mind, using, of course, a unified message, strongly projected, resonant and personal.

Each and every one of you are key elements of our future success. With all of us working in concert, we *can* reverse the widespread public disaffection with what is, undoubtedly, the world's best medical care. ▲



Eugene P. Johnson, M.D.
President

Letters to the Editor

Health Benefits, Hidden Costs

I read your article in the January 20th issue of *Illinois Medicine*, regarding the rising costs of health benefits. The article was informative and concise, but I was searching for information on a segment of medical costs not addressed in the chart from Hewitt Associates or in the article "The Rising Administrative Costs of Medical Care."

It would be interesting to know the large hidden costs due to administration and management of medical care, including costs associated with administration of laws and third-party payer forms.

May I suggest that this would be a good subject for a follow up article.

Sam J. Mulopulos, M.D.
Secretary-Treasurer
The Illinois Radiological Society

Kudos for *Illinois Medicine*

Congratulations on the Society's new publication, *Illinois Medicine*. If the first few issues are a good indication of the standards you intend to maintain for the periodical, you have established an excellent forum for open, objective discussion of the health matters facing Illinois today.

I strongly share the Society's philosophy that, even for the most difficult and controversial of issues, straightforward public debate is beneficial to us all. *Illinois Medicine* provides a high quality arena for public discussion of current health issues. The paper is well-produced, attractive and a pleasure to read.

Good luck on future issues. Please count on the continued cooperation and support of the entire staff of the Illinois Department of Public Health for information or insight on public health topics you are considering for upcoming editions.

Bernard J. Turnock, M.D.
Director
Illinois Department of Public Health

CARAFATE®
(sucralfate) Tablets

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987; 9(4):395-399.

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Carafate® for the ulcer-prone NSAID patient

Aspirin and other nonsteroidal anti-inflammatory drugs weaken mucosal defenses, which may lead NSAID users to become prone to duodenal ulcers.[1] For those NSAID users who do develop duodenal ulcers, CARAFATE® (sucralfate/Marion) is ideal first-line therapy. Carafate rebuilds mucosal defenses through a unique, nonsystemic mode of action. Carafate enhances the body's natural healing ability while it protects damaged mucosa from further injury. So the next time you see an arthritis patient with a duodenal ulcer, prescribe nonsystemic Carafate: therapy for the ulcer-prone patient.

Unique, nonsystemic
CARAFATE®
sucralfate/Marion

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Please see brief summary of prescribing information, and reference on adjacent page.

0160N8

ISMIE and ISMIS elect officers

FRED Z. White, M.D., a family physician from Chillicothe was reelected Chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors on Wednesday, April 5, 1989 at the Westin O'Hare Hotel in Rosemont. Walter W. Whisler, M.D. was reelected Vice Chairman and Irwin A. Smith, M.D. was reelected Secretary. Richard Geline, M.D., of Skokie, an orthopedic surgeon, was elected to the Board of Governors at the Exchange's annual meeting of policyholders on April 5.

The Illinois State Medical Insurance Services Board of Directors, the board governing the Exchange's attorney-in-fact was selected at the Illinois State Medical Society's reorganizational meeting on Sunday, April 9, 1989. Board members chosen were Robert C. Hamilton, M.D., Alfred J. Clementi, M.D., Ulrich F. Danckers, M.D., Phillip D. Boren, M.D., Alfred J. Kiessel, M.D., and Ronald G. Welch, M.D. Alexander R. Lerner was named Secretary-Treasurer. ▲

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

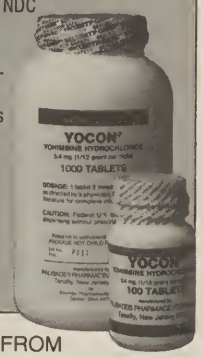
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—A 56-year-old woman went to an internist complaining of upper right quadrant abdominal pain, bloating and discomfort after eating, and occasional constipation alternating with mild diarrhea.

Initial diagnoses and subsequent diagnosis—Initial diagnoses were irritable bowel syndrome and later, acute diverticulitis. Eventual diagnosis by another physician was colon cancer.

The case in brief—The physician examined the patient and suspected irritable bowel syndrome. He prescribed appropriate medication and advised the patient to avoid certain foods. Two months later, the patient telephoned the office to report that the problem still existed and that she was not feeling any better. The physician switched the patient to another medication. Six months then elapsed. The patient came to the office again, this time complaining of left abdominal cramping and discomfort, continuation of symptoms similar to those she initially described, and extreme fatigue. The physician never saw the patient again. Eight months later, she consulted another physician who diagnosed cancer of the sigmoid colon.

The resulting claim—The patient sued the internist for failure to diagnose and treat cancer.

The outcome of the claim—The cancer metastasized to the patient's right lung and the colon cancer recurred. The case was settled for $550,000.

Why problems arose with this case—Consultants who reviewed this case concluded that the initial treating physician was negligent because he failed to order proper investigative tests when on her second visit to the office the patient presented a changed set of symptoms. Although it was uncertain if the patient had the mid-sigmoid cancerous lesion at the time of the last visit, it was impossible to defend the suit because the physician's records were sketchy and inadequate. Even more damaging was the fact that the physician altered the charts after he received notice of the claim, to suggest that there were no findings indicative of a diagnosis of cancer at the first visit or at the time of the second phone call, and that he had considered ordering a sigmoidoscopy and barium enema on the patient's second visit.

The points this case makes—A comprehensive, continuing medical record is critical to the defense of any professional liability action. Judges and juries find it difficult to believe that a physician can accurately and fully recall everything about a particular case, including specific diagnostic, examination and treatment details years after an alleged incident of negligence occurs. The medical record provides the most objective evidence of what transpired. It can be a silent but powerful advocate for the physician's actions when well prepared or a devastating weapon against a physician when it is not. A defensible medical record should contain:

☐ A complete patient history, with reasons for the patient's visit, a description of symptoms and complaints, in the patient's own words when possible, and a medication and allergy history.

☐ The type of examination conducted and any physical findings or lack of findings. The absence of findings may be as important in court as a significant finding. Otherwise, it can be alleged that the physician never actually performed the examination.

☐ The physician's diagnosis, any treatment rendered at the visit, and any prescriptions written.

☐ Future treatment plans or recommendations, including orders for specific tests or procedures, and the possibility of hospitalization or referral to another physician.

☐ The date on which the patient is advised to return. If the decision is left to the patient, this should be so recorded.

☐ Test results sent to the physician following the patient's visit. These laboratory slips and other forms should be clipped to the record carefully so they do not get lost.

☐ All telephone messages from the patient or the doctor's call to the patient. These should be dated and placed in the chart. In the case described, there was no record of the patient's telephone call to the office reporting that her problem still persisted. Nor was there any record of a medication change by the physician as a result of the phone call. Physicians also should devise a system for recording telephone calls made or received when they are out of the office.

☐ A system for assuring patient follow-up which is incorporated into the chart, either a "tickle" file for pursuing test results, calling back the patient for a progress report, or assuring that the patient comes back as instructed. If a patient does not return when requested, a follow up letter should be sent, emphasizing the importance of continued attention to the problem, and a copy filed in the chart.

Finally, consultants expressly say that no medical record should ever be altered after notification of a potential suit. Such changes destroy the credibility of the entire chart and subject the physician in court to charges of falsifying information. Changes made to the record in the process of its preparation should be crossed out with a single line, leaving the original note still legible, with the change written nearby and initialed and dated by the appropriate individuals at the time they are made. Any Illinois State Medical Inter-Insurance Exchange policyholder who alters medical records jeopardizes his or her continued liability insurance. ▲

Good news on 1989-90 premiums

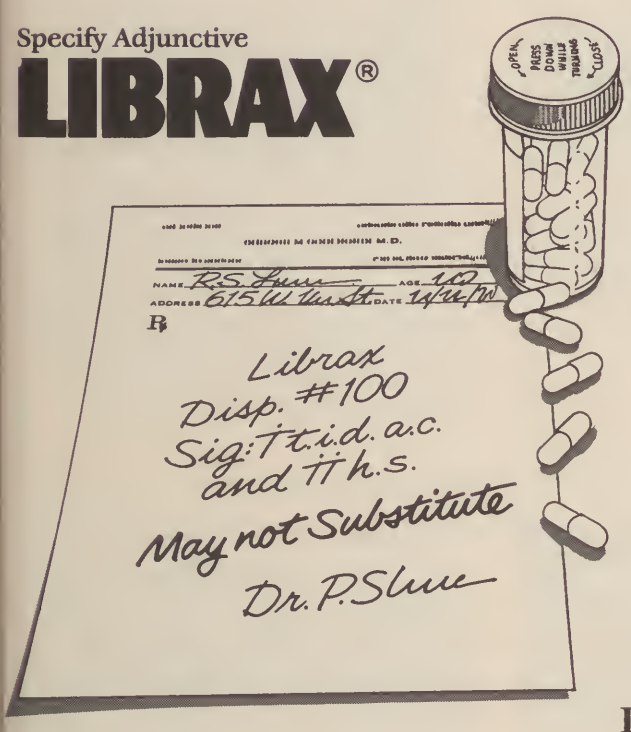
"PHYSICIANS ENTERING their fourth year of claims-made policies with Illinois State Medical Inter-Insurance Exchange (ISMIE) will see practically no change in premiums for the 1989-1990 policy year," announced Robert C. Hamilton, M.D., Chairman of Illinois State Medical Insurance Services (ISMIS) at the ISMIE network session held on Saturday, April 8, 1989 during the ISMS annual meeting. Dr. Hamilton said the rates, effective July 1, 1989, reflect no significant increases, with physicians in their fourth year experiencing a plus or minus two percent premium change. Dr. Hamilton attributed the rate stabilization this year to the effects of the 1985 and 1987 tort reform measures and to the company's careful administration.

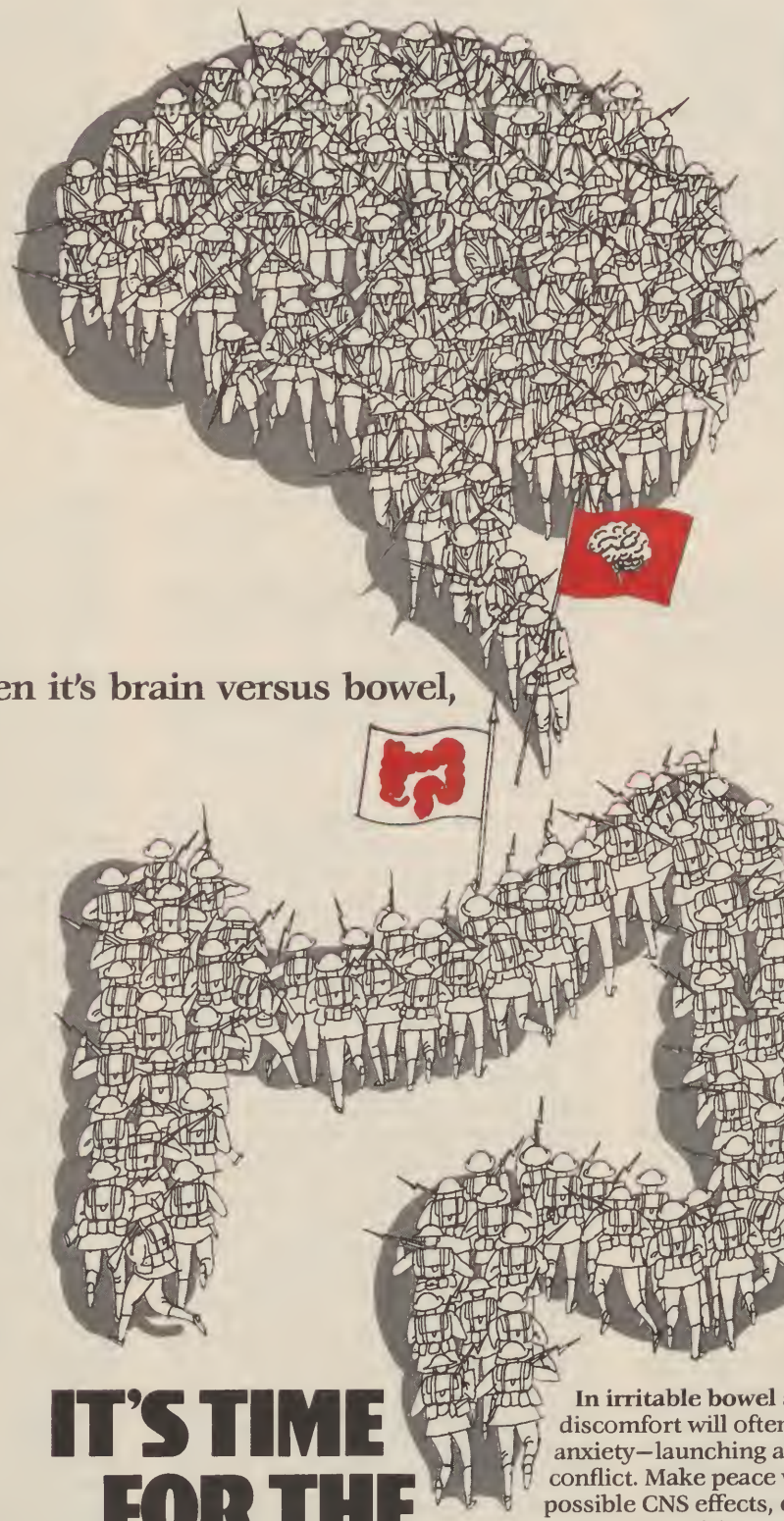
"Overall, the news is good for policyholders," Dr. Hamilton said. However, physicians in Macon County will see a premium increase because they will be moved up to Territory II from Territory III, due to adverse loss experience over the last three years. No other changes will be seen in the new program year.

Fred Z. White, M.D., ISMIE Chairman, reported new Exchange initiatives to the physicians and others who attended the network meeting. "The Exchange has formed a new Risk Management Committee to develop and implement comprehensive educational programs to help policyholders improve patient care and reduce liability," Dr. White said. "Also, the Physicians Assistance Program, funded by the Exchange, will continue to assist physicians with drug, alcohol or emotional impairments. We can't prove that this program prevents a certain number of suits, but we know that this program must favorably affect the quality of care and therefore contribute to reducing the incidence of malpractice."

Dr. White had good news for physicians who would like to be Exchange policyholders, but who have not joined due to the necessity for purchasing tail coverage from their previous carrier. "Our ISMIE Long Range Planning Committee suggested, and the Board agreed, that we should authorize ISMIS to proceed with the development of a plan for offering a prior acts policy," Dr. White said. He said that offering prior acts coverage, like the offering of a clinic and group hospital policy, is just another way the Exchange is trying to enhance the product for the policyholders *and* retain market share. ▲

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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Meet your newly-elected ISMS officers!

ILLINOIS MEDICINE *interviewed the newly elected officers of ISMS, and asked each of them to answer the following question: "What do you consider to be the major problem confronting medicine in Illinois today?"*

Eugene P. Johnson, M.D., Casey—President



Physicians have voiced frustration that they seem to be completely thwarted by their inability to give the kind of care—a high quality of care—they want to their patients. Part of this is misunderstanding, but a great deal more is the multiplicity of barriers thrown up between physicians and what they think is best for the patient. Medicine must continue to address this if we wish to improve the quality of health care, which I think is the ultimate goal of every physician attending the ISMS annual meeting."

James H. Andersen, M.D., Chicago—President Elect



The multiple problems confronting physicians in Illinois all boil down to one issue: the freedom to practice medicine. We were trained to take care of patients, yet there are many influences that hinder this care . . . third party payors . . . utilization reviews . . . malpractice threats . . . government regulations . . . in-house restrictions. The freedom to practice medicine . . . the art for which we trained our whole lifetime . . . is the goal of organized medicine. It's in the best interest of our patients."

Robert M. Reardon, M.D., Bloomington—First Vice President



The major challenge is the need for communication in this time of change. Physicians have built communications bridges to our patients, but we also need to build bridges to business, labor, the legislature and other professions.

Physicians must also lead the way in improvement of patient care. We can't compromise quality of care—that's an absolute!"

Boyd E. McCracken, Sr., M.D., Greenville—Secretary Treasurer



One of the most pressing problems facing state societies and medicine is lack of access to care for those individuals who don't have insurance. The medical profession needs to deal with this issue in the manner and tradition we have always pursued—caring for patients regardless of their ability to pay. I know this tradition is continued today by many physicians throughout the state. As physicians are asked to provide care, they must have protection against medical liability."

Delegates vote

(continued from page 1)

for Medical Care (CCFMC), which is Illinois' PRO, the regulation was actually promulgated by the Health Care Financing Administration (HCFA) and reflects current federal law.

Several physicians questioned the implementation of the regulation. They urged direct ISMS intercession—especially with CCFMC—on behalf of physicians who are the subject of such notification. In its report to the House, the reference committee noted that ISMS has already filed written comments with HCFA opposing the regulation. Moreover, the ISMS Council on Economics currently represents Illinois physician interests with CCFMC, and has had success in modifying many of the state PRO's objectionable practices.

Accordingly, the House adopted a substitute resolution calling on ISMS to continue to oppose the HCFA regulation, to continue monitoring and pursuing solutions to PRO policies that negatively affect the practice of medicine and to inform the membership of these efforts.

Delegates also debated the need to educate the American people about the comparative advantages of the American system of health care delivery to those of Canada and Great Britain.

At issue was a resolution by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society, asking the AMA to undertake a massive public education campaign to counter a recent Louis Harris and Associates poll that said 29 percent of the American people preferred the British system and 61 percent preferred the Canadian system.

While the reference committee acknowledged the issue's importance, its recommendation to limit such a campaign to physicians captured the indignation of the original resolution's supporters.

William H. Wehrmacher, M.D., of Cook County, said that "the American people must be informed that they will be jumping from the frying pan into the fire if they accept either the Canadian or British system. Both recognize that their systems are absolutely dreadful." The House eventually agreed, overwhelmingly approving the original resolution.

The House, recognizing the increasing concern among physicians posed by the questionable telephone techniques of external review organizations, directed the ISMS to pursue appropriate solutions to the problem, including legislation. Many doctors testified that they have been subjected to abusive inquiries for confidential patient information by third party payors and other review organizations, many of whom may be outside Illinois. The ISMS was also directed to request that the AMA address the problem.

Two resolutions were considered controversial enough to be referred to the Board of Trustees for further study. One would attempt to address the acute shortage of qualified obstetrical care in downstate rural counties by urging the Illinois Department of Public Aid to contract with qualified physicians and certified nurse-midwives to provide such care, and to explore umbrella indemnification options for these professionals.

The other resolution asked ISMS to lobby appropriate state agencies regarding the policies and procedures that HMOs use to inform clients about what "experimental" therapies are or are not covered. While expressing support for the resolution's intent, the reference committee said that the term "experimental" requires clearer definition.

In other action, the House approved a resolution directing the ISMS to continue to encourage physicians to have their HMO contracts reviewed by their attorneys before signing them.

Animals in research, trauma center designations

The House of Delegates affirmed support for the use of animals in research, and approved resolutions on remedial medical education and trauma center designation revisions, all major issues at the annual meeting.

Following introduction of Resolution 4 by Harold L. Jensen, M.D., for the Board of Trustees, the House voted to approve an expansion of current ISMS policy on the use of animals in research and education. The revised policy statement reaffirms ISMS' support for the concept and clarifies its position advocating humane treatment for animals in research.

"Animal rights [advocates] are increasingly vocal, and to their credit, bring up that [methods of] handling animals are not always humane when they are used in research or for educational purposes," commented H. Constance Bonbrest, M.D., an ISMS Trustee who spoke in support of the resolution. Joan E. Cummings, M.D., newly elected Speaker of the ISMS House of Delegates, also said she is "strongly in favor" of animals in research, since "clearly, computer-generated models cannot substitute for animal models."

Resolution 36, introduced by Raymond E. Hoffmann, M.D., Trustee for the Winnebago County Medical Society, asked ISMS to support revisions in the Illinois Department of Public Health (IDPH) trauma center law to make requirements for level 1 trauma centers more flexible, so, for example, a hospital in a small urban area need not have a trauma surgeon available, in-house, 24 hours a day. The resolution, approved by the House, also favored limiting the number of designated trauma centers in Illinois.

The problem is the unnecessary costs of maintaining 24-hour trauma staff on site, generating higher hospital bills for patients, Dr. Hoffmann said. "They're all being charged extra money just to cover the administrative overhead of having extra people sleep in the hospital. The system is costing Rockford $3.4 million a year, according to hospital estimates," he explained. If the rules were changed, he noted, the high costs "could be eliminated or put toward paying for uncompensated care and reducing hospital bills."

Dr. Hoffmann advised area planners to "mandate that only one hospital [in each area] be a trauma center, or change the rules and regulations somewhat to allow very prompt response without having the rigidity of the American College of Surgeons guidelines." He also prefers the use of standards, instead of regulations. "I don't care what they call the hospitals, 'Level 1', or 'A's, or 'superhospitals'. What I care about is the extra money that's being spent."

Remedial medical education

The House of Delegates voted to adopt Substitute Resolution 38, regarding remedial medical education for "clinically deficient" physicians. Submitted by Robert L. Bertrand,

(continued on next page)

Joan E. Cummings, M.D., Chicago—Speaker of the House of Delegates



"The major issue is to formulate health policy for medicine. We're facing cost containment, in essence, as a substitute for clear direction from the public as to where they want medicine to go. The problems we face, including increasing regulation, reflect the fact that we don't have a clear path. By default, much of the frustration falls on the physicians. As regulations trickle down, physicians and their patients face the problem without a clear sense of how to resolve the issue and [how to] attempt to sway the people making the regulations.

Raymond E. Hoffmann, M.D., Rockford—Vice Speaker



"Probably the single most important concern facing Illinois physicians today is the continuing limitation on and intrusion into their practice by third party payors, governmental regulators, and review agencies such as the PRO.

Practicing medicine today means more than just caring for patients. It means fighting policy makers whose "best" intentions end up harming high quality, individualized care.

As physicians, we must continue to resist 'cook book' medicine."

Harold L. Jensen, M.D., Harvey—Chairman, ISMS Board of Trustees



"The great issue to be decided in the next two years is the resolution of the developing dichotomy between an expected high level of medical care and the present lack of funds to pay for it.

The Congress establishes a budget for Medicare. If it's inadequate, 'rationing' of services—with all the negative connotations and personal distress—is imposed on the physicians in the hospitals.

The difficulties imposed on the health care industry, which arise from policies of inadequate funding, are presented to the media (and therefore the public) as poor planning, as greed, and as venality."

Adriano S. Olivar, M.D., Chicago Heights—2nd VP, ISMS Board of Trustees



"If I had to pick one problem confronting medicine today, I'd say it is the rising cost of medical care.

The vast majority of money spent on medical care goes to meet the demand for expensive, state-of-the-art facilities for modern-day care, for sophisticated machinery and diagnostic and treatment technologies.

The budget for medical care is a favorite and visible target for cutting. Funding for the medically underserved as well as services for the chemically dependent, which has become a national problem, will be cut."

Delegates *continued*

M.D., delegate for the Winnebago County Medical Society, the resolution called for establishment of a task force by the ISMS Board of Trustees, in cooperation with organizations and agencies concerned with physician competency, to study implementation of a remedial education program, and report findings in a timely fashion. The Illinois PRO, Crescent Counties Foundation for Medical Care, is already in the process of developing a program, and will seek ISMS accreditation for it.

"The remedial education issue came up because many review organizations are beginning to apply sanctions to physicians, and no organized activities were available for physicians found to be clinically deficient," commented Dr. Bertrand. "Some type of process needs to be established to allow physicians who are clinically compromised to be diagnosed in terms of the exact deficiency, to allow an organized way for the deficiency to be corrected, and then to certify that [it] has been corrected."

OB services, residents' stress management

Lengthy testimony was heard by the reference committee regarding Resolution 32, submitted by Roger N. Klam, M.D., for the Jackson County Medical Society. The resolution was among several developed by physicians from southern Illinois to address the lack of OB care downstate.

The resolution called for definition and guidelines for birthing centers in existing rural hospitals, and asked that the IDPH assist in developing prenatal centers and services for low-risk obstetrical patients, as well as transportation to birthing centers and tertiary care centers. "Small hospitals have stopped doing obstetrics due to the cost of having a level 1 unit. The resolution would enable these hospitals to care for low-risk pregnant women, and would serve the public by not having these women travel 50-100 miles for care."

Following debate, the House of Delegates adopted a substitute resolution to be forwarded to IDPH supporting the "concept of physician-directed and supervised low-risk obstetrical services (not centers) within rural community hospitals in underserved areas".

The House of Delegates also adopted several resolutions submitted by the Resident Physicians Section. RPS Substitute Resolution 43, on policies for HIV infected residents, encouraged Illinois residency program directors to follow the guidelines for Universal Precautions of the Centers for Disease Control; to educate resident physicians on compliance with the guidelines; and to comply with state laws on AIDS confidentiality and HIV information.

Following positive testimony in reference committee concerning the need for stress management and crisis intervention programs for resident physicians, the House adopted Resolution 46, submitted by Gail Herman, M.D., for the RPS. "Early intervention can prevent problems later on. It has been shown that stress reduction programs during residency decrease the incidence of malpractice at teaching hospitals," she commented.

Resolution 15, favoring the establishment of hospital medical staff committees to assist impaired or distressed physicians submitted by Harold L. Jensen, M.D. for the Board of Trustees, was adopted with slight modification to include house staff.

Another important resolution addressed by the House concerned medical licensure, submitted by Biswamay Ray, M.D., delegate from the Chicago Medical Society. As amended and adopted, it advocated ISMS support creating a single examination pathway for medical licensure of foreign and American medical graduates.

Public health issues

Public health issues ranging from the prerogatives of physicians at an emergency scene to new, improved anti-smoking measures captured debate at the Illinois State Medical Society's annual House of Delegates meeting.

Responding to *Chicago Tribune* columnist Mike Royko's recent story about a physician who was arrested after trying to assist the victim of a gunshot wound, ISMS delegate Wayne Leimbach, M.D., Kane County, submitted a resolution seeking to clarify the role of physicians who happen upon a medical emergency scene. As finally adopted by the House, the resolution calls for the medical society "to seek rule changes or legislation to clearly define the prerogative, authority and role of physicians who have identified themselves at the scene of a medical emergency." In the case cited by Royko, the victim died after a police officer with emergency medical technician training failed to heed the on-the-scene physician's advice.

While paramedics are well-trained to follow strict protocols of emergency treatment, several physicians who spoke out on the floor of the ISMS House voiced concern that paramedic protocols should not preempt a physician's medical judgment about emergency patient care.

Chicago delegate Alan Roman, M.D., put the resolution in perspective. "The concern arises over who takes responsibility for care of the patient, over who's in command at the scene." According to Dr. Roman, if a physician on the scene is willing to take over the liability, the paramedic will usually allow the physician to assume primary care. "In the ideal situation, they interface very well," Dr. Roman stressed. He added that, "it was important that the resolution was brought up, because it serves as a stepping off point to discuss physician-paramedic relations in emergency situations."

Anti-smoking measures

Also before the House were several resolutions dealing with tobacco. The House voted overwhelmingly to "strongly urge that all accredited hospitals in Illinois establish a non-smoking policy, including a complete ban on smoking in patient care areas." Sponsored by the ISMS RPS, the resolution stemmed from concern that medicine should set a good public health example. "In our hospitals, where the best of medical care supposedly is available, we're still allowing people to hurt themselves by smoking. They're also hurting people in close proximity to them," commented Gail Williamson, M.D., RPS representative, who testified in favor of the resolution during reference committee debate.

Rockford area physicians also entered two anti-smoking resolutions. The House amended and then approved one "calling for federal legislation requiring the printing of the Surgeon General's warning in a clear and conspicuous manner on all tobacco products." The other, which recommended large-print warnings,

(continued on next page)

ISMS elects new trustees, delegates; several re-elected to terms

THE ILLINOIS State Medical Society elected new leaders from across the state Sunday, April 9, 1989, at the Westin O'Hare in Rosemont, Illinois.

Newly elected Trustees of the ISMS Board include: second district: Edward J. Fesco, M.D., of LaSalle; third district: Jere E. Freidheim, M.D., of Chicago, Arvind Goyal, M.D., of Rolling Meadows, and Pedro A. Poma, M.D., of Melrose Park; fifth district: Jane Jackman, M.D., of Springfield; and twelfth district: William Kobler, M.D., of Rockford.

Arthur R. Traugott, M.D., of Urbana, was reelected Trustee of the eighth district and Raymond A. Dieter, M.D., Glen Ellyn, was reelected Trustee of the eleventh district.

AMA delegates chosen

Albino T. Bismonte, M.D., of Waukegan, is the newly elected AMA delegate. Reelected were: Alfred J. Clementi, M.D., of Arlington Heights; Jere E. Freidheim, M.D., of Chicago; Robert C. Hamilton, M.D., of Chicago; Harold L. Jensen, M.D., of Harvey; Alfred J. Kiessel, M.D., of Decatur; Morgan M. Meyer, M.D., of Lombard; Harry A. Springer, M.D., of Evanston; Arthur R. Traugott, M.D., of Urbana; and Ronald G. Welch, M.D., of Belleville.

James Ahstrom, Jr., M.D., of Downers Grove is the newly-elected AMA alternate delegate. Reelected were: Claire M. Callan, M.D., of North Chicago; Ulrich F. Danckers, M.D., of River Forest; Earl E. Fredrick, M.D., of Chicago; Silvana Y. Menendez, M.D., of Belleville; Robert M. Reardon, M.D., of Bloomington; Donald K. Rokosch, M.D., of Danville; Joseph H. Skom, M.D., of Chicago; and M. LeRoy Sprang, M.D., of Evanston. ▲

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Counties of Monroe, Perry, Randolph, St. Clair, Washington
Ronald G. Welch, M.D., Belleville

Eleventh District
DuPage County
Raymond A. Dieter, Jr. M.D., Glen Ellyn**

Twelfth District
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago
William E. Kobler, M.D., Rockford*

**newly-elected*
***reelected*

Delegates

(continued from page 9)

at least one-half as big as the advertising typeface, went down to defeat. It was aimed at making more prominent the anti-smoking message which accompanies billboard advertisements widely utilized by tobacco companies. The reference committee and the full House, however, preferred to keep the medical society focused on already-existing policy to work toward a complete advertising ban for tobacco products.

Hazardous waste, highway safety

Hazardous medical waste—how to define it and provide for its proper disposal—also generated discussion at the reference committee and on the House floor. Physician delegates referred the resolution, which called on ISMS to help introduce and support state legislation explicitly defining hazardous medical waste and establishing guidelines for its proper disposal, to the Board for further study and action.

The House failed to adopt a Rock Island County Medical Society resolution advocating an alcoholic beverage tax to finance treatment of alcohol-related highway trauma. "This resolution raises the much broader issue of uncompensated care," said the reference committee report, "[which] is beyond the scope of this resolution."

ISMS physicians also declined to recommend a hike in Illinois' compulsory auto/motorcycle liability insurance limits, after hearing the reference committee question the "philosophical conflict" such a resolution would create. "ISMS has consistently opposed efforts by the plaintiffs bar to mandate minimum levels of physician malpractice insurance," noted the reference committee report. "The Society has opposed such legislation because it expands the physicians' 'deep pocket,' thus worsening the malpractice liability climate."

Medicine and the media

ISMS will study additional ways to enhance the image of the medical profession, and explore effective and speedy ways to answer negative comments made about medicine in the media, as a result of a resolution passed at its 1989 annual meeting.

By amending and passing Resolution 55, brought to the 1989 House of Delegates by Chester C. Danehower, M.D. for the Peoria County Medical Society, ISMS agreed that the image of medicine is often tarnished unfairly and that better ways need to be developed to remedy medicine's negative image. The resolution also mandates ISMS to ask the AMA to continue efforts to enhance the image of medicine.

Dr. Danehower said there is a strong feeling in Peoria that the AMA is not responding as quickly as it should when bad things are said about the profession. "We are aware that things are being done, but we don't think they are being done as hard as they should be," he noted. "We should learn from mistakes we have made in the past and we should try it another way. We need to have speakers trained so that they can go out and talk in a professional manner to the media, clubs, schools—whatever it takes to get our message out. People love *their* doctor, but they hate doctors. It should be a very easy thing to convert that to 'we like our doctor, we like doctors.'"

Dr. Danehower said he doesn't think physicians should advertise, but "if the medical society does it, on behalf of physicians, we can do a lot of good. About four years ago, doctor bashing was horrible in Peoria," he said. "But we formed a speaker's bureau and went around to the media and discussed our problems—we had such a negative image. But we made ourselves available to the media. We each had our areas of expertise. As a result, we really picked up our image."

"Doctors tend to relate only to themselves," Dr. Danehower added. "They don't go out in the community and join service clubs. I've really pushed this in Peoria."

Dr. Danehower stressed that his resolution was not meant to attack the ISMS or the AMA, because he has respect for both organizations and the people involved. He agreed that the amended resolution was a positive action and said he was very happy with it. "I can go back to Peoria and show them we did something," he said.

Residents' benefits

"Considering the nature of our jobs, residents should have as good or better benefits as hospital employees," said Gail Herman, M.D., a Chicago resident physician and sponsor of Resolution 47 (A-89) for the Resident Physicians Section. Members of the reference committee which first considered the resolution and the full House agreed with Dr. Herman and passed the resolution asking ISMS to urge Illinois residency programs to provide health, life and disability insurance to residents.

Dr. Herman said residency programs do not offer uniform benefits, and many do not offer any benefits to residents. "Residents are in the prime of their lives, but often in debt," she explained. "They make low salaries, and their jobs are often dangerous. I know residents who have been hit and shot." Herman also said that the thought of contracting hepatitis B or HIV infections haunts many residents.

Residents with health benefits often do not have coverage for their families. Purchasing health insurance for themselves and their families is a major expense for many residents. And, according to Dr. Herman, "many residents worry constantly about becoming ill or disabled" when they don't have health insurance.

One reason so many residency contracts don't include benefits is that they are costly to the institution. Dr. Herman said a good benefits package could be an effective recruiting tool for graduate medical education directors in attracting the best residents. "The salaries offered by most residency programs are usually very similar," Dr. Herman said. "It's the benefits that make the difference."

The reference committee, in support of the resolution, cited the Illinois State Medical Society/Chicago Medical Society's Physicians, Benefits Trust's free $10,000 life insurance policy for resident members during the course of their training as one way in which organized medicine in Illinois is already addressing this need.

Board Briefs

The Illinois State Medical Society (ISMS) Board of Trustees met on Thursday, April 6, at the annual meeting of the ISMS House of Delegates, held at the Westin O'Hare Hotel. Full minutes are available to any member upon request; these synopses provide brief highlights.

Executive Committee highlights

IN AN ADVISORY letter sent to Governor Thompson in February, ISMS urged him to exercise Illinois' right to opt out of the 1988 federal Medical Waste Tracking Acts' two-year demonstration project. The Executive Committee report said that "there was no need for Illinois to be subject to the law due to already existing activities in the state." Noting that the Illinois Environmental Protection Agency has formed a task force on medical waste to study the problem and explore options, the letter, signed by Harold L. Jensen, M.D., Chairman of the Board of Trustees, told the governor that "ISMS will be an active and supportive participant in this task force, which we believe is preferable to the federal effort."

ON THE TOPIC of HIV testing confidentiality and billing, the Executive Committee noted that legal counsel for the Illinois Department of Public Health indicated IDPH would not oppose physicians including an HIV test in a "batch" bill where the HIV test is not identified. Disclosure to an insurer of the fact that the test had been performed is possible only with the written consent of the patient. Without written consent, however, the procedure cannot be billed to an insurer without potential breach of patient confidentiality. The Executive Committee noted that further discussion is also continuing as to what material can be placed within the medical or hospital record as a result of testing when the HIV test is included.

Council news

JAMES L. McGEE, M.D., Chairman of the Council on Medical Services, reported on proposed state rule changes for ambulatory surgical treatment centers (ASTCs), with two major revisions impacting physicians. The board approved the council's recommendation that "only physician offices certified by Medicare as ASCs or which permit other providers to use their surgical suites should be required to be licensed by the state as ASTCs." Furthermore, the council said, "physicians who have operating suites attached to their offices who are not certified by Medicare as ASCs or who merely bill Medicare a surgical fee should be exempt from licensure." Pending legal counsel review, these recommendations will be forwarded to the Illinois Department of Public Health.

THE BOARD ACCEPTED the council recommendation that ISMS pursue new legislative strategies seeking amendment of the Illinois Clinical Laboratory Act to: "1) permit physician office labs to use present personnel for a two-year period, in lieu of hiring medical technicians; and 2) allow physicians who have trained their personnel to perform a few specialized complex tests to utilize these persons without having to hire medical technicians and be forced to meet the requirements of a higher level of regulation." The Board agreed with the council's recommendation to submit legislation to delay the effective date of the Illinois Clinical Laboratory Act for entities previously not regulated until the federal law regulating physician office labs becomes effective in 1991.

JANE JACKMAN, M.D., Chairman of the Council on Public Relations and Membership Services, reported on the broad outlines of an outreach program directed toward Illinois senior citizens and membership organizations. Potential components include development of informational materials, a physician's speaker's bureau and dialogue sessions between seniors and physicians. On the media front, outreach elements would include print and broadcast public service announcements. The board accepted the council's recommendation to "develop the outlined senior citizens program, and to meet with senior citizen groups and or representatives to test-market the proposal."

The Young Physicians Committee will sponsor a May 20 seminar in DuPage County, featuring hospital/physician joint ventures, according to Dr. Jackman, who noted that the committee's successful November 1988 educational seminar attracted "healthy attendance." The committee encourages membership and ISMS involvement by offering programs of special relevance to young physicians, and anticipates cosponsorship of future programs with county medical societies and the ISMS Resident Physicians Section.

The ISMS Hispanic AIDS education program is underway, with a brochure translated and printed, and a speaker's bureau now being promoted. Radio public service announcements on AIDS and teens are slated for translation soon, said Dr. Jackman.

THE COUNCIL ON Education and Manpower and the Committee on CME Activities continue to monitor closely the issue of focused remedial CME, following a recent conference cosponsored by the AMA, AHA (American Hospital Association), and ACME (Alliance for Continuing Medical Education) and other organizations. According to Boyd E. McCracken, Sr., M.D., chairman of the council, a system may be developed eventually to accredit organizations monitoring remediation programs to ensure that programs meet specified standards, assure confidentiality and validate learning achievement.

New initiatives from the Illinois Department of Public Aid (IDPA) to address quality of care concerns include consideration of sponsoring a continuing medical education course in conjunction with a medical school, and development of a newsletter to highlight areas of physician difficulty with the department's medical quality review process, according to Arthur R. Traugott, M.D., Chairman of the Committee on Third Party Payment Processes. The board reaffirmed its previous endorsement of the initiatives, and accepted the committee's recommendation that the Chicago Medical Society participate in the development of the department's CME initiative and MQRC newsletter.

The committee also reported it is reviewing and monitoring the "implied warranty" concept used as denial for payment to a physician by a private insurance company for services provided to a patient. The committee expressed interest in reviewing other examples of this type of problem experienced by members.

ISMS COMMENTED ON proposed "safe harbor" regulations in a March 20 letter from Harold L. Jensen, M.D., Chairman of the Board of Trustees, to the Health Care Finance Administration (HCFA), regarding the agency's issuance of a notice of proposed rule making identifying physician payment practices that will not be subject to criminal prosecution under Medicare/Medicaid fraud and abuse/anti-kickback provisions. The letter noted that there was a "very limited range of activities" defined which would be "safe harbors" and a very indistinct identification of those which are not. "This places an impossible burden on the physician community," the letter said. ISMS strongly urged that the Office of the Inspector General more adequately define both approved and prescribed behavior, and requested the Internal Revenue Service and the Federal Trade Commission to publish advisory letters on these issues, so that physicians have a better understanding of what is safe practice and what is not. ▲

Nominations and appointments

THE BOARD OF Trustees approved Peter E. Friedell, M.D., of Chicago, for reappointment to the Illinois Cancer Council board. The nomination of Alfred J. Kiessel, M.D., of Decatur, to serve on the Crescent Counties Foundation for Medical Care's small area analysis committee was also approved.

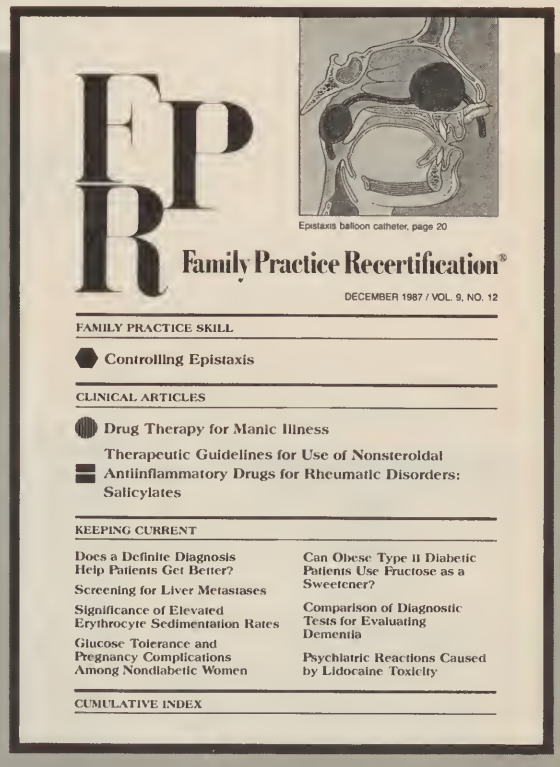
THE BOARD ALSO endorsed the candidacy of William McDade for the AMA Medical Student Section Governing Council, and announced support for the candidacy of Bruce Doblin, M.D., of Chicago, for the position of Vice-Chairman of the AMA-RPS Governing Council in the June, 1989 election.

TWO ADDITIONAL at-large positions to the Governing Council of the ISMS Hospital Medical Staff Section received board approval. A. Rashied Shedbalkar, M.D., of Kane County, will represent downstate, and Arthur I. Broder, M.D., was named to represent Chicago.

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Rarely associated with fatigue, drowsiness, depression, constipation, sexual dysfunction, or postural hypotension.[2-5,7-8]*

Maintains or improves exercise capacity.[8]

*Please see Adverse Reactions section of brief summary.

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Also available: 120-mg capsules

†Dosages must be adjusted to each patient's needs, starting with 60 to 120 mg twice daily.

BRIEF SUMMARY
CARDIZEM® SR
(diltiazem hydrochloride)
Sustained Release Capsules
CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, (3) patients with hypotension (less than 90 mm Hg systolic), (4) patients who have demonstrated hypersensitivity to the drug, and (5) patients with acute myocardial infarction and pulmonary congestion documented by x-ray on admission.

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (nine of 2,111 patients or 0.43%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction 24% ± 6%) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM (diltiazem hydrochloride) in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using this combination.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** Mild elevations of transaminases with and without concomitant elevation in alkaline phosphatase and bilirubin have been observed in clinical studies. Such elevations were usually transient and frequently resolved even with continued diltiazem treatment. In rare instances, significant elevations in enzymes such as alkaline phosphatase, LDH, SGDT, SGPT, and other phenomena consistent with acute hepatic injury have been noted. These reactions tended to occur early after therapy initiation (1 to 8 weeks) and have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in some cases, but probable in some. (See PRECAUTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Dermatological events (see ADVERSE REACTIONS section) may be transient and may disappear despite continued use of CARDIZEM. However, skin eruptions progressing to erythema multiforme and/or exfoliative dermatitis have also been infrequently reported. Should a dermatologic reaction persist, the drug should be discontinued.

Drug Interaction. Due to the potential for additive effects, caution and careful titration are warranted in patients receiving CARDIZEM concomitantly with any agents known to affect cardiac contractility and/or conduction. (See WARNINGS.) Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

As with all drugs, care should be exercised when treating patients with multiple medications. CARDIZEM undergoes biotransformation by cytochrome P-450 mixed function oxidase. Coadministration of CARDIZEM with other agents which follow the same route of biotransformation may result in the competitive inhibition of metabolism. Dosages of similarly metabolized drugs, particularly those of low therapeutic ratio or in patients with renal and/or hepatic impairment, may require adjustment when starting or stopping concomitantly administered CARDIZEM to maintain optimum therapeutic blood levels.

Beta-blockers: Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated, but available data are not sufficient to predict the effects of concomitant treatment in patients with left ventricular dysfunction or cardiac conduction abnormalities.

Administration of CARDIZEM (diltiazem hydrochloride) concomitantly with propranolol in five normal volunteers resulted in increased propranolol levels in all subjects and bioavailability of propranolol was increased approximately 50%. If combination therapy is initiated or withdrawn in conjunction with propranolol, an adjustment in the propranolol dose may be warranted. (See WARNINGS.)

Cimetidine: A study in six healthy volunteers has shown a significant increase in peak diltiazem plasma levels (58%) and area-under-the-curve (53%) after a 1-week course of cimetidine at 1,200 mg per day and diltiazem 60 mg per day. Ranitidine produced smaller, nonsignificant increases. The effect may be mediated by cimetidine's known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pass metabolism of diltiazem. Patients currently receiving diltiazem therapy should be carefully monitored for a change in pharmacological effect when initiating and discontinuing therapy with cimetidine. An adjustment in the diltiazem dose may be warranted.

Digitalis: Administration of CARDIZEM with digoxin in 24 healthy male subjects

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For hypertension







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Enhances blood flow to key target organs, including the kidney and heart.[9]

Maintains renal function with no disturbance of fluid or electrolyte balance.[10]

Reduces left ventricular hypertrophy[6] and has no adverse effects on serum lipids.[2,5,11]

increased plasma digoxin concentrations approximately 20%. Another investigator found no increase in digoxin levels in 12 patients with coronary artery disease. Since there have been conflicting results regarding the effect of digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing CARDIZEM therapy to avoid possible over- or under-digitalization. (See WARNINGS.)

Anesthetics: The depression of cardiac contractility, conductivity, and automaticity as well as the vascular dilation associated with anesthetics may be potentiated by calcium channel blockers. When used concomitantly, anesthetics and calcium blockers should be titrated carefully.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded from these studies.

The adverse events described below represent events observed in clinical studies of hypertensive patients receiving either CARDIZEM Tablets or CARDIZEM SR Capsules as well as experiences observed in studies of angina and during marketing. The most common events in hypertension studies are shown in a table with rates in placebo patients shown for comparison. Less common events are listed by body system; these include any adverse reactions seen in angina studies that were not observed in hypertension studies. In all hypertensive patients studied (over 900), the most common adverse events were edema (9%), headache (8%), dizziness (6%), asthenia (5%), sinus bradycardia (3%), flushing (3%), and 1° AV block (3%). Only edema and perhaps bradycardia and dizziness were dose related. The most common events observed in clinical studies (over 2,100 patients) of angina patients and hypertensive patients receiving CARDIZEM Tablets or CARDIZEM SR Capsules were (ie, greater than 1%) edema (5.4%), headache (4.5%), dizziness (3.4%), asthenia (2.8%), first-degree AV block (1.8%), flushing (1.7%), nausea (1.6%), bradycardia (1.5%), and rash (1.5%).

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS

Adverse	Diltiazem N=315 # pts (%)	Placebo N=211 # pts (%)
headache	38 (12%)	17 (8%)
AV block first degree	24 (7.6%)	4 (1.9%)
dizziness	22 (7%)	6 (2.8%)
edema	19 (6%)	2 (0.9%)
bradycardia	19 (6%)	3 (1.4%)

DOUBLE BLIND PLACEBO CONTROLLED HYPERTENSION TRIALS (continued)

ECG abnormality	13 (4.1%)	3 (1.4%)
asthenia	10 (3.2%)	1 (0.5%)
constipation	5 (1.6%)	2 (0.9%)
dyspepsia	4 (1.3%)	1 (0.5%)
nausea	4 (1.3%)	2 (0.9%)
palpitations	4 (1.3%)	2 (0.9%)
polyuria	4 (1.3%)	2 (0.9%)
somnolence	4 (1.3%)	—
alk phos increase	3 (1%)	1 (0.5%)
hypotension	3 (1%)	1 (0.5%)
insomnia	3 (1%)	1 (0.5%)
rash	3 (1%)	1 (0.5%)
AV block second degree	2 (0.6%)	—

In addition, the following events were reported infrequently (less than 1%) or have been observed in angina trials. In many cases, the relation to drug is uncertain.

Cardiovascular: Angina, arrhythmia, bundle branch block, tachycardia, ventricular extrasystoles, congestive heart failure, syncope.

Nervous System: Amnesia, depression, gait abnormality, hallucinations, nervousness, paresthesia, personality change, tinnitus, tremor, abnormal dreams.

Gastrointestinal: Anorexia, diarrhea, dysgeusia, mild elevations of SGOT, SGPT, and LOH (see hepatic warnings), vomiting, weight increase, thirst.

Dermatological: Petechiae, pruritus, photosensitivity, urticaria.

Other: Amblyopia, CPK increase, dyspnea, epistaxis, eye irritation, hyperglycemia, sexual difficulties, nasal congestion, nocturia, osteoarticular pain, impotence, dry mouth.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. Definitive cause and effect relationship between these events and CARDIZEM therapy cannot yet be established.

Issued 1/89

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Analysts preview political future under Bush

by Kevin O'Brien

THE MARKET RESEARCHER spoke on Friday, while the unabashed political ideologue followed on Saturday. Thus, delegates and guests to the 1989 ISMS annual House of Delegates meeting heard two very Republican, but decidedly contrasting versions of how George Bush won the presidency, and what his victory bodes for the future.

Bush pollster and now senior adviser to the president Robert Teeter's review of campaign '88 took ISMS delegates on a journey of numbers and demographics. He described a vastly different work force than 15 years ago. He said that Americans today are better educated and vitally concerned with issues such as drugs, education, and the environment. He revealed how those concerns, reflected in the polls, helped dictate the daily message. He cited the development of a new American political coalition—only the sixth time in U.S. history (the last being the New Deal) such a coalition has formed—that created the Reagan/Bush majority despite party affiliation. Finally, Teeter cast George Bush's future task in terms of specific problems that demand solution, epitomizing the "pragmatic" White House.

Patrick J. Buchanan, on the other hand, immediately boasted "I'm not only a Republican, I'm a *right-wing* Republican." He credited the politics of confrontation—Bush constantly attacking on issues of prison furloughs and the pledge of allegiance—for Bush's success. But he labeled the president's post-election style the politics of compromise. Instead of casting the future in terms of issues and problems begging resolution, Buchanan listed choices that Bush will have to make. These include choices that affect the psyche of the body politic; choices between the conservative, middle-American movement on whose values Bush rode to victory, and the Washington, D.C. establishment of which he is a part.

Both men agree that the campaign's overriding goal was to ensure that the American people viewed Dukakis as the Massachusetts liberal they said is anathema to a majority of the electorate. They echoed each other when they claimed that controlling the daily agenda was critical. But Teeter described the strategic planning as would any social scientist. "Nothing makes any difference except your ability to get 270 electoral votes," Teeter told the delegates. "And I may not have learned too much in my life, but I have learned every permutation of 270."



Robert Teeter



Patrick J. Buchanan



U.S. Representative Richard Durbin (D-Springfield), a member of the House Budget Committee, addressed the ISMS Public Affairs Breakfast.

Soap opera campaign

With Buchanan, delegates got a blow-by-blow account of the campaign as soap opera. His rendition of the adventures of "Snow White and the Seven Dwarfs" to the ultimate selection of the "Little Duke" revealed a Democrat party that never realized the "country was ready to elect a Democrat, but they weren't ready to elect a liberal." He painted the picture of the media's shark-like "feeding frenzy" in J. Danforth Quayle's home town that only managed to enrage the party's conservatives. The television image of the future vice president being devoured by the national press corps in front of his family and life-long friends and supporters turned a potential debacle into an unanticipated masterstroke. Buchanan reminded his listeners that if all this was just soap opera, it didn't matter because "a soap opera is a lot more interesting than a position paper."

However, it was each man's view of Bush's upcoming challenge that really challenged ISMS delegates. From Teeter's perspective, a successful Bush presidency depends on solutions—solutions to "some very big problems that have been glossed over in one way or another for a very long time." Teeter said that Bush cannot escape addressing the budget deficit and that a tax increase is probable next year. He must solve the trade deficit and the savings and loan crisis. Teeter said something must be done about the country's nuclear weapons factories which are environmental disasters waiting to happen. Finally, Teeter said that for the first time in years, the voters are demanding the president develop a domestic agenda that will address drugs, education, health care and issues relating to the changing work force.

Yet, for Buchanan, Bush's problem is one of fundamental ideology. He said that it is okay for Bush to try the kinder and gentler approach. "It's his right, he's elected president." But, Buchanan is not sure the "politics of compromise and consensus" will work. He said that the primary characteristic of recent successful presidencies (the first terms of Richard Nixon and Ronald Reagan) was confrontation and that the American people accept this. Moreover, Buchanan said Bush has some fundamental choices to make and that he believes the John Tower nomination was an "omen of things to come."

Bush's choices

Buchanan said Bush cannot let the U.S. Congress dictate his policy or he risks losing the conservative support he needs to govern. The future tests will be whether Bush stands up to Congress on his "read my lips" pledge for no new taxes, appoints and then stands by ideologically conservative Supreme Court appointments, and whether Bush chooses to bail out the Soviet Union's "economic empire which is in a state of collapse" or gives in to Mikhail Gorbachev's desire for a strategic weapons agreement, which in the view of many conservatives, "is not a deal we can't take." If Bush chooses wrong, Buchanan said, "his conservative movement will walk on him." The not-so-subtle implication: that will be it for George Bush.

In sum, Robert Teeter, the pragmatist, and Patrick Buchanan, the "right-wing Republican", provided distinct vision of how we got here and where we have to go that were as entertaining as they were sobering. ▲

The politics of health care grow

by Kevin O'Brien

HEALTH CARE is the issue that concerns Americans most but politicians least, Bush pollster Robert Teeter told the ISMS House of Delegates at their annual meeting.

"The one issue, interestingly enough, if you look at the polls, where you have greater voter interest and demand that the politicians have not talked about is the whole issue of health care," Teeter said. He said that is because "no one has found out the solution for it yet."

Teeter said that polls show that only a small percentage of the public is currently dissatisfied with health care delivery, but that 30 percent to 40 percent say they are apprehensive about the future. He said that everyone in Washington, including Sen. Edward Kennedy, realizes that the U.S. cannot afford a national health care system, but that the issue is not going away.

Teeter told the House that "either we are going to have the best possible health care for everybody in the country, and we're going to find some way to pay for it . . . or we're going to have to ration it and nobody is willing to stand up and say that, at least no politician is."

Consequently, Teeter said, Congress' current method of handling the problem is to kick it down to local governments. "Congress and the politicians have said we're going to take this nibble by nibble and push that decision back to the hospitals, to the doctors, to the state officials, and the local government officials."

The result will be fewer federal health care dollars forcing the local entities to make the rationing decisions. Moreover, Teeter said that corporate America is becoming a major new player in the setting of health care policy. He said that many corporate executives feel they can no longer afford to continue funding the system the way they have.

"I have thought for 10 or 12 years that the whole question of the cost of health care would be a major issue in some election down the road, and I still think it will be," Teeter said. But he concluded by warning that though the issue is at the top of the public's agenda, "it is low on the politician's agenda." ▲



Delegates listened intently as national political experts previewed the future for health care policy under the Bush administration. More than 300 delegates from across Illinois attended the ISMS House of Delegates annual meeting at the Westin O'Hare.

ISMS Auxiliary: Making the most of the medical family

"A POSITIVE voice for medicine." That's the 1989 theme for the Illinois State Medical Society Auxiliary (ISMSA), an organization of some 2300 physician spouses throughout Illinois. It's meant to convey a changing image, as well as the essence of a host of new programs the auxiliary will be mounting in the coming year, according to incoming president Nancy Hoffmann of Rockford.

The growing variety of the serious programs and activities stretches the traditional, stereotypical image of auxilians as hospital fund raisers and symphony supporters, Hoffmann says. "No one else is speaking for the physician's family," she notes. "Our theme is really three-fold. We want to be a positive voice for physician family issues, for public health education and for legislative advocacy."

Acknowledging that "voluntarism is encountering some difficult times right now because many of our spouses are career people," Hoffmann emphasizes that this trend has actually benefitted the auxiliary. "We've had to make ourselves more businesslike, and streamline the organization," she says. Toward that end, the auxiliary is turning its attention to more issue-oriented projects, and ones which involve specific, "short term commitments" for which even busy people can find some time to participate.



ISMS auxiliary members covered a meaningful agenda at annual meeting.

AIDS education programs

AIDS is high on the auxiliary's list, says Hoffmann. She cites the organization's growing concern about AIDS and the medical workplace, "because we've heard a lot about the risks which physicians are meeting, and we have questions about what can be done—both legislatively and within hospitals—to make the workplace safer."

Becoming more active in the medical society's "AIDS and adolescents" project is another objective. That program involves a statewide physician speakers bureau to educate high and junior high school students on the risks of AIDS transmission. "We have a longstanding history of working with the schools on public education," notes Hoffmann, "and we realize that our adolescent population is very much at risk [for AIDS transmission]."

Medical family support

Each of the many county auxiliaries which comprise ISMSA sets its own agenda for action and educational programming. According to Hoffmann, many of them will focus this year on building "support groups" to help physician family members deal with the special stresses of life in a medical family. "Malpractice lawsuits are one great source of family stress," explained Hoffmann, "but the lack of time, the fact that the family often has to take somewhat of a second place role when the physician unexpectedly rushes off to the hospital" is also very stressful. The Adams County auxiliary's support group, formed almost two years ago, serves as the model for others starting up now.

Helping physicians impaired by alcohol, drugs or other physical or mental disabilities—as well as their families—is a related auxiliary priority. Hoffmann reports that Kathy L. Angres, M.S., R.N., will serve as physician's family assistance chairman on the ISMSA board. Herself a physician's spouse, Angres is active in the treatment and rehabilitation of impaired health professionals and their families. She serves on the state medical society's Physician Assistance Committee, which provides confidential counseling and referral resources for impaired doctors.

On June 6, the auxiliary will conduct its annual "day at the legislature," offering an opportunity for physicians' spouses from all over the state to talk with state representatives and senators at the Capitol. Hoffmann encourages spouses—whether or not they're actually members of the ISMSA—to attend the session. "With mandatory assignment up for debate, mounting concern about AIDS in the health care workplace and possible consideration of legislation to protect retirement assets from the impact of malpractice settlements, it's a timely project for our organization," she adds. "It's a great place for physicians' spouses to get their feet wet learning about important medical family issues." ▲

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Physicians, civic leaders feted for public service with a smile

by Emily Klose

Going that "extra mile" to help those who need it . . . Speaking out in the community . . . Giving every ounce of time, energy and expertise to serve your neighbors. That's what real *public service is all about.*

FOR THE THIRD consecutive year, the Illinois State Medical Society has presented public service awards to individuals demonstrating exemplary community involvement. On April 8, ISMS honored the 1989 winners at its House of Delegates meeting. The award recipients included two physicians, Patrick Staunton, M.D., and Paula Youngberg Arnell, M.D., and two non-physicians, Ed Jucewicz and Monsignor Ignatius McDermott.

Nominations were solicited from every county society and specialty society in the state. Each winner has made exceptional contributions to public service and outreach efforts.

Monsignor Ignatius McDermott, Chicago

His formal title is Monsignor Ignatius Daniel McDermott. But on Chicago's near west side, where he has lived and worked for the last 43 years, he's "Father Mac." His public service award is a tribute to his devotion to the hungry, the homeless, alcoholics, and addicts.

His philosophy is simple. "The Lord never gives up on anyone in the world until the undertaker picks up the body," he says.

During his 53 years as a priest, Father Mac has earned a reputation for tenacity. He helps men and women fight their way back to lives without alcohol or drugs. His goal is to help them recover not just their sobriety, but their self-respect.

This priest is a familiar sight on the near west side, a sturdy 79-year-old man with a head of white hair and calm blue eyes set in a ruddy face.

Father Mac didn't plan to become a missionary. As a boy growing up on Chicago's south side, he dreamed of becoming a parish priest. He attended Quigley Preparatory Seminary in Chicago, then completed his studies at St. Mary of the Lake Seminary in Mundelein, Illinois.

After his ordination in 1936, Father Mac was assigned to Maryville Academy, a home in Des Plaines for abused children. He first encountered Chicago's notorious Skid Row district when he went there in search of a child's father.

In 1941, he was assigned to Our Lady of Peace Parish in Chicago. As an assistant pastor, he counseled families troubled by alcohol abuse. In 1946, Father Mac was appointed Associate Administrator of the Catholic Charities of the Archdiocese of Chicago, a post he holds to this day. He began canvassing the bars, flophouses, alleys, and streets full-time when he joined Catholic Charities. He was dubbed "the pastor of Skid Row" for his work with public inebriates.

In 1963, Father Mac founded the Addiction Prevention Services Department of Catholic Charities. Today, he is recognized as a pioneer in the development of programs for alcoholism and drug abuse.

Over the past four decades, Father Mac has counseled, consoled, fed, sheltered, and tried to inspire thousands of needy persons. "I'm a cheerleader and a morale builder for them," he said.

The culmination of his life's work was the establishment in 1983 of the McDermott Foundation, which oversees many of the programs he operates. McDermott Center houses Haymarket House, "the first free-standing, social setting detoxification center in Illinois," and Cee's Manor, a 35-bed residence for recovering alcoholics. A third section, Cooke's Manor, provides overnight shelter.

Father Mac has always detested the concept of soup lines. At McDermott Center, clean modern dining facilities allow the homeless to eat in peace and dignity. The dining rooms serve meals to 150 to 200 persons a day, he said.

Father Mac's own 17-hour days begin at 6 a.m. with the celebration of mass. Then he spends as much time as possible at McDermott Center.

On this day, he put a gentle hand on the shoulder of a forlorn man cradling his head in his hands. "I'm feeling kind of sick," the man told him. "You'll be better tomorrow," Father Mac told him with certainty. "The sun's gonna shine."



ISMS Public Service award winners (from left): Patrick Staunton, M.D.; Msgr. Ignatius McDermott; Paula Youngberg Arnell, M.D.; and Ed Jucewicz.

Paula Youngberg Arnell, M.D., Rock Island

Paula Youngberg Arnell, M.D., accepted her public service award on behalf of all physicians who donate time, energy, and expertise to their communities. "I'm accepting this award only as a representative of physicians who work anonymously in the field of public service," she said. "Many physicians are doing this work and are never recognized."

Dr. Arnell, a specialist in anatomic and clinical pathology, has a long career as a public servant, including 16 years of work with the Cancer Society, both at the local and state level. Her quiet dedication to medicine and her commitment to Rock Island have earned her a reputation as an outstanding example of what physicians can and should do in providing service to the community.

Dr. Arnell claimed her interest in medicine and community involvement was sparked during childhood. Her father, Paul Youngberg, M.D., was a family practitioner in Rock Island and an active member of the Illinois State Medical Society, serving on its Board of Trustees in the late 1960s. As children. Dr. Arnell and her sister often accompanied him on rounds.

She attended Augustana College in her hometown of Rock Island, where her interest in community involvement grew. "Augustana serves the community," she said. "I received an education as well as values, and was taught to achieve my full potential."

Dr. Arnell graduated from the University of Iowa Medical School, and chose to specialize in pathology. "Pathology puts the academic part of medicine into a community setting," she said.

Dr. Arnell completed her residency, returned to Rock Island, and was immediately recruited to be president of the local chapter of the American Cancer Society. The year was 1970, and she was a newly minted physician in an area where new doctors are scarce.

During her six-year term as president of the Rock Island County Unit of the Cancer Society, Dr. Arnell's interest in oncology deepened. Throughout her years of service with the local and state cancer societies, she developed numerous prevention and information programs.

Lutheran Hospital in Moline, where Dr. Arnell has served as Chairman of the Pathology Department and Director of Clinical Laboratories since 1970, has a major cancer program. In 1984, she established the hospital's Quad Cities Regional Screening and Diagnostic Breast Center. "I wanted to take away scary hospital examining room fears as much as possible," she said. The Breast Center, a self-referral screening program, provides "a warm, non-threatening environment for women," she said.

Dr. Arnell has been active in many other community activities. When two local blood banks merged, she was a founding member of the resulting Mississippi Valley Regional Blood Bank. In addition, she has devoted 12 years of service to the Augustana College Board of Directors, including six years as chairman. The Lutheran Church has also benefitted from her countless hours of public service.

In between obligations to her profession and her community, Dr. Arnell manages to spend time with her husband, a radiologist, and their three children. But she is clear about her role as a physician. "Most doctors go into medicine to cure or comfort patients," she said. "If you care for patients, you care for people. And people are the community."

Ed Jucewicz, East St. Louis

Forty years ago, Ed Jucewicz sold sporting equipment, insurance, appliances, and a variety of other goods and services. Then he was offered a job as Executive Director of the St. Louis Boys Club, and he began selling the promise of a better life to scores of underprivileged youngsters.

The public service award he accepted from the Illinois State Medical Society recognizes his four decades of work with various Boys Clubs in Illinois and Missouri.

There aren't many obstacles Jucewicz hasn't faced and overcome in his career. "Things would get bad and I'd want to throw in the towel," he said. "But the determination of the kids to make it has always kept me going." The kids usually come from impoverished neighborhoods where trouble is a constant companion. Most are from broken or dysfunctional families. Poverty, crime, drugs, prostitution, and unemployment have a heavy hand in shaping the lives of many of the youngsters who've found their way to Jucewicz's door.

Twenty-three years ago, Jucewicz became Executive Director of the Boys Club in East St. Louis. The club is one of the few places in that city where 7-to-15-year-olds can find organized sports and recreation. A membership in the boys club fills time when the kids aren't in school.

The lure of street gangs is great in East St. Louis, a city which faces grave social and economic problems. Jucewicz's club competes with gangs for members. "The choice is up to the kids," he said. "We help young people make the right choice."

Some members come strictly for the sports and recreation—checkers, pool, boxing, whiffle ball, volleyball, and the biggest draw, basketball. For others, the club is a quiet haven that offers a library and homework help. And Jucewicz is always around to listen to the kids and talk about their problems. "It's important for them to have someone to talk to," he said.

By his own reckoning, Jucewicz has influenced the lives of hundreds of youngsters. His philosophy seems to be that there are few bad youngsters, only bad environments. "In my 40 years, I bet there's not more than three kids that were written off," he said.

Jucewicz was born 67 years ago in Salem, Illinois, a small town 60 miles from East St. Louis. He grew up on the south side of St. Louis.

As a young man, Jucewicz studied for the priesthood for three years. He later discovered his true calling as a leader and administrator of boys clubs.

According to Jucewicz, about 150 boys and girls visit the East St. Louis Club each day. Policemen, teachers, and professional athletes are among former members, and serve as role models to others. "It's a family here," Jucewicz said. "It's the club that beats the streets."

(continued on next page)

(continued from page 16)

Patrick Staunton, M.D., Oak Park

The Illinois State Psychiatric Institute (ISPI) was scheduled for budgetary extinction in the summer of 1986. Patrick Staunton, M.D., a clinical psychiatrist, worked tirelessly to prevent the closure of the facility. His acceptance of the Illinois State Medical Society's Public Service Award highlights the career of a physician whose successful campaign to sustain ISPI laid the groundwork for future planning for the care of the mentally ill in Illinois.

For 33 years, Dr. Staunton's work as a clinical practitioner has gone hand-in-hand with his work as an advocate for patients dependent on public services for medical and psychiatric care.

He was drawn into the spotlight two and a half years ago when severe financial cuts appeared imminent for several mental health facilities in Chicago. "These cuts, if implemented, would not have permitted ISPI to carry on as a research and training institution," Dr. Staunton said. "I thought it was unwise public policy to jeopardize by these cuts the viability of the one research institution in the state that was studying mental illness."

In addition to ISPI, two other state mental health facilities were endangered—the Institute for Juvenile Research and the Illinois Institute for Developmental Disabilities. Using their contacts in the state legislature, Dr. Staunton and others voiced strong opposition to the proposed cuts. Governor Thompson eventually reinstated funding for the three institutions, and appointed a committee to study the problem of mental health care services. From September 1986 until January 1987, Dr. Staunton served as chairman of Thompson's task force on the future of mental health in Illinois.

As a staff psychiatrist at ISPI from 1959 to 1969, Dr. Staunton learned to appreciate the value of such research facilities. He said, "Research offers the best hope that some day in the future we'll be able to prevent or perhaps control the enormous problem that creates mental illness."

Dr. Staunton has been an active member of the Illinois Psychiatric Society, serving as its president in 1980 and was chairman of the ISMS Council on Mental Health from 1975 to 1978.

Dr. Staunton was born and raised in Swinford, Ireland. His father was a general practitioner whose six children all became physicians. Dr. Patrick Staunton attended medical school in Dublin, and emigrated to Chicago in 1952.

Dr. Staunton is currently Chairman of the Division of Psychiatry at Lutheran General Hospital in Park Ridge, a position he has held since 1979. Besides administration and teaching duties at the hospital, he sees patients about 20 hours a week. "One of the joys of the private sector is seeing patients," he said. "It's very gratifying." ▲

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ISMS Annual Meeting Highlights



Left: *Eugene P. Johnson, M.D., (L) new ISMS President, chats with Robert M. Reardon, M.D., new First Vice-President.* Below: *A delegate comments at one of several reference committees reviewing major issues for House of Delegates action.*





Above: *Nancy Hoffmann, new ISMS Auxiliary President, pulls winning raffle ticket benefitting the AMA-ERF contribution to Illinois medical schools.* Below: *AMA Chairman Dr. and Mrs. Jack Ring.*



Right: *George T. Wilkins, Jr., M.D., ISMS Trustee and IMPAC chairman.* Below: *Biswamay Ray, M.D., makes a point about his resolution.*







Left: *Dr. and Mrs. Harry Springer were "king and queen of the prom" at President's Night, honoring Dr. Springer as outgoing president of ISMS.*

Right: *Simone Tizes, 1988-89 ISMS-MSS Vice-Chairman and K. Gregory Lucchesi ISMS-MSS Chairman take time out from the Annual Meeting.* Below: *Orlan Pflasterer, M.D., was the hit entertainer at the IMPAC reception.*





Guests at the head table during President's Night.







Above: *Mr. and Mrs. Alexander Lerner with Dr. and Mrs. Harold E. Jensen.* Right: *William Kobler, M.D., winning the hula hoop contest at President's Night festivities.*





Above: *Past presidents of ISMS gathered for their annual gourmet dinner.* Right: *Members of the ISMS Fifty Year Club*

Annual Meeting photography by The Photo Partners, Inc.

U/I affiliation

(continued from page 2)

These include that provisions be made to ensure care to indigent patients is not disrupted during the transition period; ensure continued high-risk obstetrical care; continued participation by Michael Reese as a level I trauma center; and others (see below). Turnock also recommended that $25 million be set aside annually to expand primary health care for Chicago's poor and medically indigent.

Rush not satisfied

The board also directed the university administration to open discussions "within the general framework of the affiliations" with Rush-Presbyterian-St. Luke's Medical Center in response to Rush proposals recently offered as an alternative to the Reese/County affiliations. The board endorsed Rush's concept of a second ambulatory care center in the west side medical district, and expansion of the two institutions' nursing programs.

However, Rush issued a statement saying that it regrets that there was no "opportunity for full public discussion of an action of such far-reaching consequences for the health and well-being of the Chicago metropolitan community and beyond." The statement also said that Rush would "continue to address the issues in appropriate fashion in the days, weeks and months to come." ▲

IDPH lists conditions

In its study of the impact of the University of Illinois/Michael Reese/Cook County Hospital affiliation agreements on Chicago's health care delivery system, the Illinois Department of Public Health recommended implementation provided the following conditions were met:

- The University of Illinois/Michael Reese affiliation does not go forward ahead of the University/Cook County Hospital affiliation. The second is a necessary precondition for the first if access to health care is to be maintained.
- The proposed affiliations are implemented in such a way that services to the vulnerable populations described in the report are not disrupted, even for a brief period.
- University faculty and residents are available to provide services to former UIH patients at both MRHMC and CCH in a flexible two-hospital system formed by dual admitting privileges and joint residency programs.
- Inpatient bed capacity is increased in obstetrics, pediatrics and neonatal intensive care along the lines described in the report.
- In order to preserve access to level III perinatal services provided by the UIH network, MRHMC must provide transport, delivery and follow-up services for high risk women and infants from current UIH network hospitals, regardless of ability to pay.
- MRHMC stands by its pledge to remain in the Chicago trauma network as a level I trauma center.
- MRHMC stands by its pledge to continue UIH policies related to provision of transplantation service.
- To minimize the departure of experienced staff from the UIH facilities, Cook County takes immediate steps to reassure university employees of future employment.
- The Illinois Department of Public Aid ICARE contracts negotiated to replace the current Medicaid days provided by UIH preserve current doctor-patient relationships. That is, inpatient days are allocated so that physicians are available to provide primary and other ambulatory care.
- Outpatient services remain available and plans for construction of two new ambulatory care centers be reconsidered to accommodate a shift of primary care volume away from hospital outpatient clinics to community-based primary care systems.
- Decentralization of the inpatient system operated by Cook County through the potential acquisition of hospitals on the south side and west side of the city be extended to the outpatient side of the county system as well. ▲

Temporary license deadline nears

May 1 is the deadline for incoming residents to submit temporary licensure applications to the Illinois Department of Professional Regulation, in order to have a license in hand by July 1, 1989—the start of most Illinois residency training programs. Medical residents without temporary licenses cannot treat patients—and if they do, are subject to discipline under Illinois' Medical Practice Act.

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Dr. Kremper was a practicing OB-GYN until April of 1988 when illness forced the then 45 year-old physician to retire from practice.

Although he had been an APIC policyholder for less than a year, Dr. Kremper was given "tail coverage" at no charge due to his disability. This provision in his APIC policy saved Dr. Kremper over $119,000, and allowed him to enter his retirement with the knowledge that he would have coverage for future claims that might arise from his former practice.

Furthermore, since he had purchased APIC's "prior acts" coverage in lieu of a tail policy from his previous commercial carrier, Dr. Kremper will be fully protected for all claims that might arise from treatment dating back to July 1 of 1982 – the date he purchased his first claims-made policy from the commercial carrier.

Dr. Kremper describes his situation:

"It was difficult for me to accept having to stop my practice of medicine. But with my APIC policy still in force, I at least knew I wouldn't have to worry about what might happen if I were to get sued after I retired. And it was a big relief knowing that I didn't have to come up with an extra $119,000 in premium."

Today Dr. Kremper serves on the Board of Directors of Associated Physicians Insurance Company. His involvement there helps to assure that responding to the needs of our physician policyholders will always be a top priority at APIC. And it comes from the unique perspective of a physician who's "been there".

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"Phone first" for ISMS physician information

PROSPECTIVE PATIENTS wondering how to locate a local physician recently found help from an unlikely source: their phone bill. The March issue of the Illinois Bell customer service newsletter, "Telebriefs," received by all residential Illinois Bell customers along with their monthly billing statement, suggested that customers "call first." Illinois State Medical Society (ISMS) and Chicago Medical Society (CMS) phone numbers were listed as physician information and referral reference sources.

Don't be afraid to ask questions," was Telebriefs' message to those searching out physicians. Bell customers seem to be heeding the advice: calls to ISMS requesting physician information or referrals increased tenfold since Illinois Bell customers began receiving their bills in early March. ISMS staff is responding to as many as 20 to 30 calls daily, up from around three or four before the "Telebriefs" publicity began. Two typical caller profiles predominate: someone who, because of a recent move, needs a new physician, or someone who wants more information on a physician recommended by an acquaintance.

A common denominator is caller apprehension. Nearly all are frustrated in their search for a physician. Many have tried unsuccessfully to


Telebriefs
Illinois Bell
Need a new doctor? Call first

find a physician through other means, and most are nervous about finding the "right" doctor. Callers requesting a referral are given the number of their county medical society, which will be able to refer them to a local physician. For those asking about a particular physician, ISMS provides information on board certification, specialty, medical school attended and year graduated. By far, the most frequently asked question is whether or not a physician is board certified.

According to a CMS spokesperson, calls to that organization's physician referral service have increased steadily over the past year, as the public has become more aware that the service is available. CMS and other county medical societies give callers the names of up to three different physicians, as well as hospital affiliation and other information. Both ISMS and CMS refer special inquiries to the Illinois Department of Professional Regulation or to local hospitals and clinics. ▲

Supreme Court says no to naprapaths

THE ILLINOIS Supreme Court ruled April 20 that naprapaths are not entitled to limited licensure under the state's Medical Practice Act. In a 5-0 decision with two justices abstaining, the court upheld the state legislature's right to determine appropriate qualifications for those wanting to practice medicine in Illinois. It reaffirmed the constitutionality of the Medical Practice Act's stipulation that only those graduating from a chiropractic college are eligible for a limited license to practice medicine without using drugs or surgery.

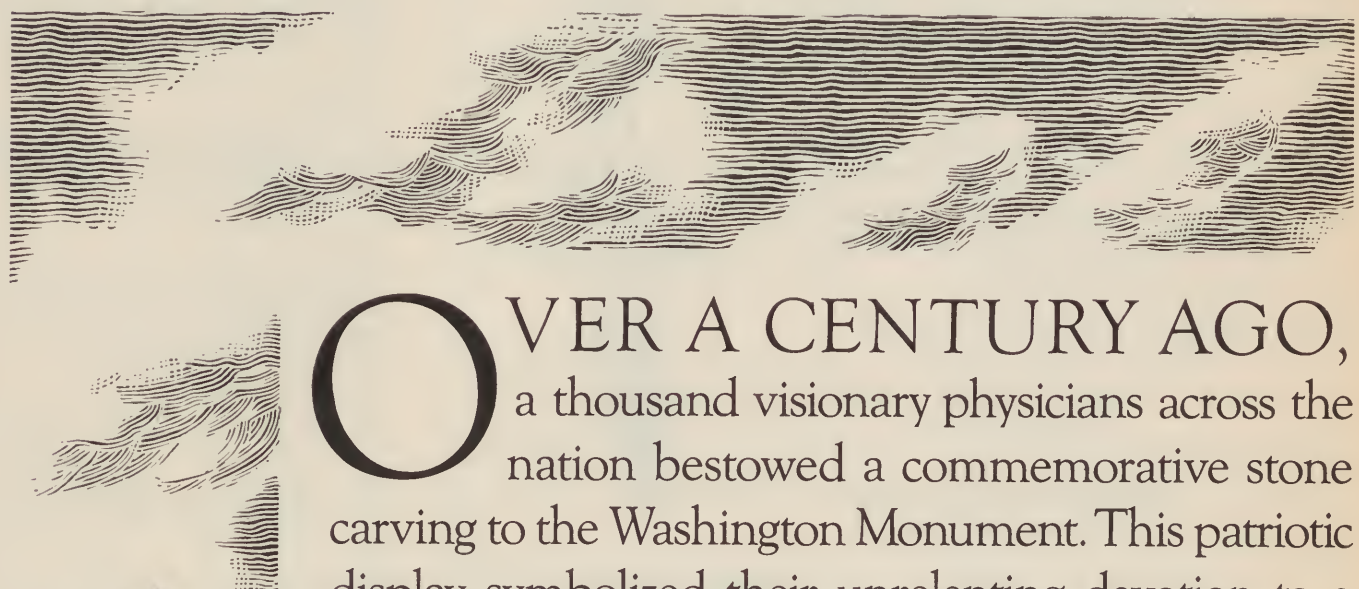
ISMS had filed an amicus brief, arguing that the legislature appropriately exercised its right to exclude naprapaths, and that naprapathy should not be equated with the practice of medicine by including it under laws governing physician licensure and discipline.

Naprapathy is "a system of therapy employing manipulation of connective tissue (ligaments, muscles and joints) and dietary measures, said to facilitate the recuperative and regenerative processes of the body," according to Dorland's medical dictionary.

The *Potts v. Illinois Department of Professional Regulation* (IDPR) decision resolves a long-running controversy between state licensure authorities and naprapaths. Naprapath Maryann Potts first sued state medical licensing authorities in 1985, after being charged with practicing medicine without a license. At that time, the Medical Practice Act allowed limited medical licensure for "any method of treatment" of human ailments without drugs or surgery. The appellate court ruled in her favor.

But in the interim, Illinois lawmakers rewrote and revised the Medical Practice Act as part of a "sunset review" process. The new 1987 act provided limited licensure *only* for those completing chiropractic education. In essence, that meant naprapaths wanting to practice in Illinois must hold chiropractic or medical degrees.

Once the new law took effect, Potts again filed suit against the Illinois Department of Professional Regulation. It was this later lawsuit that lead to the state Supreme Court ruling. ▲



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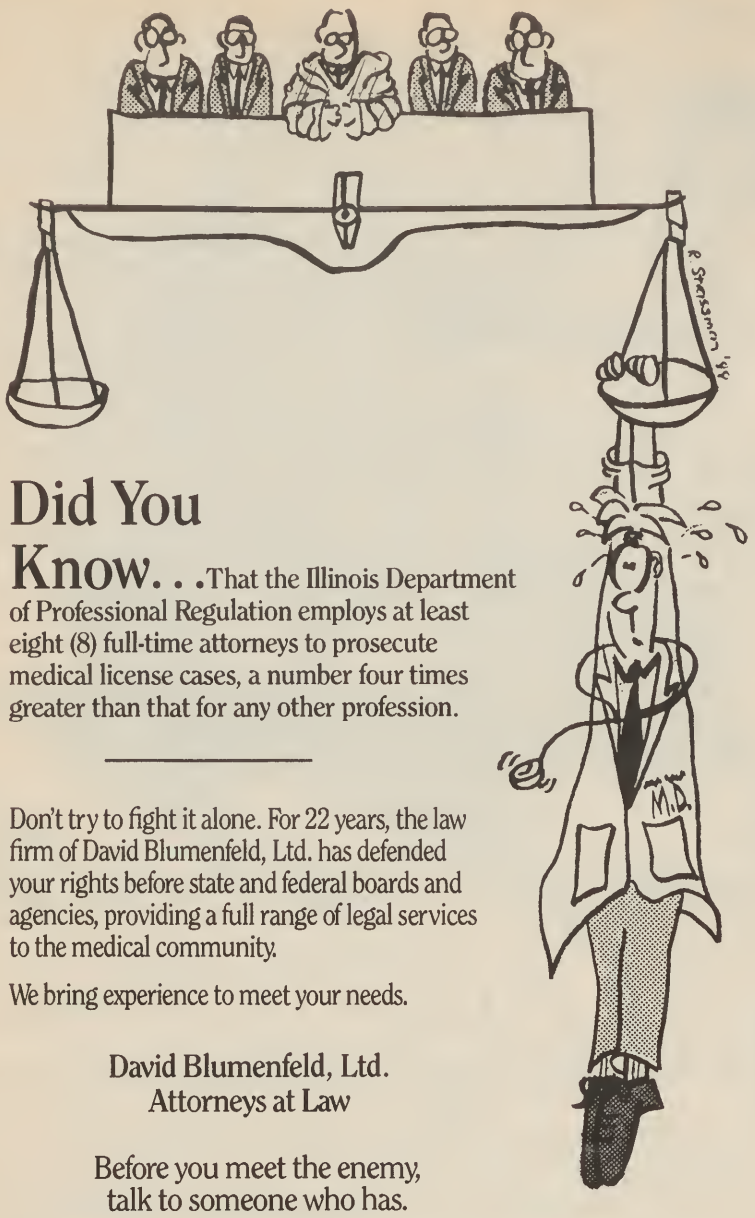
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Obituaries

****Aron**
Dr. Franz R. Aron, of Des Plaines, died December 19, 1988, at the age of 73. Dr. Aron was a 1939 graduate of Medizinische Fakultat, Universitat Basel, Switzerland.

****Bateman**
Dr. Michael A. Bateman, of Carlyle, died December 31, 1988, at the age of 79. Dr. Bateman was a 1935 graduate of St. Louis University School of Medicine, St. Louis, Missouri.

***Baxter**
Dr. Naomi S. Baxter, of Westchester, died January 16, 1989, at the age of 33. Dr. Baxter was a 1984 graduate of Rush Medical College, Chicago.

****Bennett**
Dr. Joseph R. Bennett, of Northfield, died December 27, 1988, at the age of 78. Dr. Bennett was a 1936 graduate of Rush Medical College, Chicago.

****Bird**
Dr. Harold F. Bird, of Decatur, died January 18, 1989, at the age of 82. Dr. Bird was a 1937 graduate of the Chicago Medical School, Chicago.

****Buckley**
Dr. Mortimer J. Buckley, of Frankfort, died November 11, 1988 at the age of 85. Dr. Buckley was a 1936 graduate of the Chicago Medical School, Chicago.

***Cruz**
Dr. Jaime G. Cruz, of Chicago, died October 16, 1988, at the age of 56. Dr. Cruz was a 1959 graduate of Faculty of Medicine and Surgery, University of Santo Tomas, Manila, the Philippines.

****Fagelson**
Dr. Aaron Fagelson, of Chicago, died October 20, 1988 at the age of 82. Dr. Fagelson was a 1930 graduate of Loyola University Stritch School of Medicine, Maywood.

***Flach**
Dr. Hans E. Flach, of Chicago, died July 8, 1988, at the age of 72. Dr. Flach was a 1952 graduate of Medizinische Fakultaet der Julius Maximilliams Universitaet, Wurzburg, Bayern, West Germany.

Hurwitz
Dr. Reuben Hurwitz, of Chicago, died December 18, 1988, at the age of 88. Dr. Hurwitz was a 1926 graduate of Rush Medical College, Chicago.

****Kaufman**
Dr. Irving Kaufman, of Glencoe, died January 25, 1989, at the age of 78. Dr. Kaufman was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Krajec**
Dr. Andrew Krajec, of West Salem, died January 24, 1989, at the age of 81. Dr. Krajec was a 1936 graduate of the Chicago Medical School, Chicago.

****Lehr**
Dr. Eric Lehr, of Belleville, died January 10, 1989, at the age of 79. Dr. Lehr was a 1934 graduate of Universitaet Leipzig Medizinische Fakultaet, Saxony, West Germany.

Lim
Dr. Young C. Lim, of Winnetka, died July 16, 1988, at the age of 53. Dr. Lim was a 1960 graduate of the College of Medicine Seoul National University, Seoul, South Korea.

***Lhotka**
Dr. Frank M. Lhotka, of Hinsdale, died October 6, 1988, at the age of 72. Dr. Lhotka was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

Mileris
Dr. Jonas V. Mileris, of Bourbonnais, died November 1, 1988, at the age of 64. Dr. Mileris was a 1951 graduate of Medizinische Fakultat, Georg-August-Universitat Gottingen, Germany.

***Mosiman**
Dr. William D. Mosiman, of Peoria, died January 18, 1989, at the age of 75. Dr. Mosiman was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

****Murphy**
Dr. John B. Murphy, of Park Ridge, died January 11, 1989, at the age of 76. Dr. Murphy was a 1937 graduate of Loyola University Stritch School of Medicine, Maywood.

***O'Connell**
Dr. Jerome D. O'Connell, of Evanston, died January 16, 1989, at the age of 58. Dr. O'Connell was a 1961 graduate of Loyola University Stritch School of Medicine, Maywood.

****Reinertsen**
Dr. Paul D. Reinertsen, of Canton, died January 22, 1989, at the age of 90. Dr. Reinertsen was a 1929 graduate of Rush Medical College, Chicago.

***Richards**
Dr. Gordon L. Richards, of Wilmington, died December 19, 1988, at the age of 74. Dr. Richards was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

***Roll**
Dr. Harvey C. Roll, of Wilmette, died January 1, 1989, at the age of 83. Dr. Roll was a 1932 graduate of Northwestern University Medical School, Chicago.

****Shapira**
Dr. Theodore M. Shapira, of Highland Park, died January 16, 1989, at the age of 85. Dr. Shapira was a 1931 graduate of Northwestern University Medical School, Chicago.

***Skladany**
Dr. Andrew E. Skladany, of Moline, died January 10, 1989, at the age of 59. Dr. Skladany was a 1955 graduate of Temple University School of Medicine, Philadelphia, Pennsylvania.

****Steinert**
Dr. Theodore Steinert, of Chicago, died January 9, 1989, at the age of 86. Dr. Steinert was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

Teigler
Dr. Henry I. Teigler, of Urbana, died September 5, 1988, at the age of 75. Dr. Teigler was a 1939 graduate of Northwestern University Medical School, Chicago.

Zmuidzinas
Dr. Stanley A. Zmuidzinas, of Chicago, died November 16, 1988, at the age of 93. Dr Zmuidzinas was a 1929 graduate of the Chicago Medical School, Chicago.

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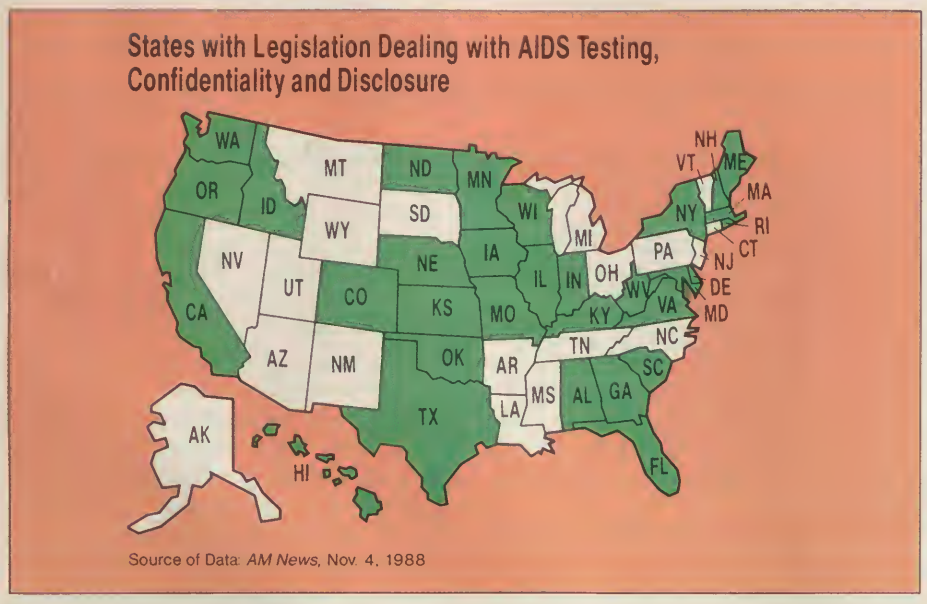
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May 12, 1989

ILLINOIS STATE MEDICAL SOCIETY

Mandatory Medicare assignment: committee roll call . . . 2



AIDS confidentiality, testing rules set

by Karen Sandrick

IN 1987, Illinois joined 30 other states in adopting legislation that directly or indirectly deals with testing for human immunodeficiency virus (HIV), including provisions for obtaining written informed consent and for maintaining the confidentiality of the patients involved.

The following year, the Illinois legislature added amendments to the AIDS Confidentiality Act which allow testing for HIV seropositivity without written informed consent in certain circumstances, but do not otherwise affect the original confidentiality requirements of the 1987 legislation. Under current Illinois law, therefore, physicians are ex-

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Making assignment mandatory: will it solve seniors' high Medicare cost woes?

THE AMERICAN Association of Retired Persons' (AARP) Illinois state legislative committee is opposing it. The Illinois State Council of Senior Citizens' Organizations is pressing hard in its favor. Illinois House Speaker Michael Madigan (D-Chicago) wants it moved to the House floor, and reportedly instructed Democrats considering the bill in committee to approve it—which they did. On May 2, the Senate Judiciary Committee followed suit by a partisan roll call. Even some of its supporters have waffled publicly on its worth. Yet, the debate is likely to escalate into a full-fledged floor fight. That could happen soon now that House and Senate committees have released it.

What's the issue? It's mandatory Medicare assignment, a "hot potato" of sorts, generating lots of debate and division as it wends its way through General Assembly consideration. H.B. 402 and its companion S.B. 180 would mandate Illinois physicians to accept assignment for all Medicare claims, or face prosecution under the state's consumer fraud statute. The legislation exempts rural areas with physician "manpower shortages," as designated by the U.S.

(continued on page 2)

Animal activists target Illinois universities' biomedical research

NEARLY A HUNDRED animal rights activists gathered their forces and took to the University of Chicago campus to kick off "World Laboratory Animal Liberation Week" April 24. They held their signs up high . . . "It shouldn't happen to a dog" . . . "Is there no justice?" . . . "End the animal holocaust" . . . "Animal liberation is human liberation" . . . and the list went on.

The Illinois demonstrations were part of a national campaign aimed at barring the use of animals in biomedical research. Animal rights activists, called antivivisectionists, also protested at Northwestern University's Evanston campus. While not currently targeting downstate medical schools, these and other activist groups are planning to broaden their campaigns downstate once they gain strength in Chicago.

An estimated 400 animal rights organizations exist across the nation, according to a 1988 study by the American Medical Association (AMA).

Marchers outside the University of Chicago protested the medical school's "dog labs." "They're not intending to find anything new by using these dogs. They know exactly what they're going to find when they use them. It's a complete waste of an animal's life," says Kay Sievers, a spokesperson for Trans-Species Unlimited, an animal rights organization that claims 30,000 members nationwide.

Sievers argues that "dog labs" are outdated, adding that most universities, including the Northwestern University Medical School, have discontinued using them.

Area university officials comment

University of Chicago spokesperson Larry Arbeiter defends the use of animals for education and research purposes, saying, "The university uses animals as a part of the training of future doctors and medical researchers. Dogs are among the animals used. And they will continue to be a part of medical training at the university as long as teachers there believe they are vital to the best medical education."

The growing controversy over using animals in biomedical research

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Mandatory assignment

(continued from page 1)

Department of Health and Human Services (HHS).

Seniors organizations split

"We are not supporting mandatory assignment," says Robert Ullrich who chairs the Illinois state legislative committee of AARP. "The reason is there are too many counties in the state that are underserved [by physicians]." The organization has more than one million members statewide.

An AARP subcommittee studied the issue over five months, and found that only 52 of Illinois' 102 counties met the federal standard of one physician per 3,500 residents. HHS defines the remainder as "health manpower shortage areas." Only 33 counties would be eligible for mandatory assignment, according to AARP, if the state public health department standard of one physician per 3000 residents is used to measure M.D. manpower. There are also underserved pockets in Cook County when judged by this standard, says AARP.

Prominent on the list of mandatory assignment supporters is the Illinois State Council of Senior Citizens Organizations, a group that says any time physicians charge a Medicare patient more than the Medicare-approved "reasonable charge," they are overcharging. The council claims that the average "overcharge" in Illinois is $45.20 and that such overcharges amounted to $138 million in 1987. "Many of our sick and elderly are at the mercy of doctors who claim their rates are controlled but who are, in fact, free to gouge their Medicare patients," said council president Jerry Prete in a news conference last month to promote the legislation.

The council claims a 250,000 membership, from a federation of over 600 senior clubs.

Sponsors and supporters speak out

House Consumer Protection Committee members voted the bill to the House floor three weeks ago, but House sponsor Representative John McNamara (D-Oak Lawn) hints he's generously delaying floor action for another week or so. "The reason I'm not moving the bill is to give people time to file amendments," he says.

So far, none have been filed, but some are anticipated. Rep. Lee Preston (D-Chicago), who chairs the committee, cited the bill's many problems but still voted for it during the panel's deliberations.

"I certainly think there should be a means test," says Preston. He estimates that half the elderly have "quite large means." A means test pegs mandatory assignment to Medicare patients' annual income. Preston also says he is not satisfied with the use of Medicare's "reasonable charge" as the basis for payment, because it does not adequately gauge physicians' cost of practice.

ISMS President Eugene Johnson, M.D., who testified before Preston's committee, wonders why Preston cast a deciding vote to release the bill in light of all the problems cited. "The committee could have amended it, or refused to release it without at least a guarantee of some improvements," says Dr. Johnson. "None of those things happened."

In the Senate, William Marovitz (D-Chicago) is mandatory assignment's chief sponsor.

ISMS continues to fight

Mandatory assignment of Medicare charges would decrease the elderly's access to medical care "exactly as we've seen it happen in Medicaid, Dr. Johnson believes. He predicts that patients with the means to pay might go out of state for procedures requiring a high degree of skill, if the pending legislation were to cause Illinois specialists to stop or limit treatment of Medicare cases. Dr. Johnson also suggests accessibility to primary care physicians might be reduced.

In committee hearings, he noted that Medicare's "reasonable charge" is in many cases below the physician's cost of providing the service. Only public aid rates are consistently lower, Dr. Johnson said.

Physicians who do not accept assignment are limited to what they may charge by the Medicare-defined "maximum allowable actual charge" (MAAC). Dr. Johnson says 1989 MAACs are based on physicians' 1984 actual charges. Since that year, Congress has limited total increases for most of those charges to 3 percent, well below a 16 percent inflation rate.

In addition, federal law restricts a physician from charging more than his usual fee, even if the MAAC is higher, according to Dr. Johnson's testimony.

"Most Medicare beneficiaries pay for medical services at a significant discount whether the physician accepts assignment or not," Dr. Johnson's testimony said.

Illinois' and other states' experience

As of January, 1989, 41 percent of Illinois physicians accepted the Medicare "reasonable charge" as payment in full for all their Medicare patients. But many physicians not accepting assignment all the time do consider it on a case-by-case basis. Over 68 percent of Illinois Medicare claims are paid on assignment, meaning physicians receive only the "reasonable charge."

Illinois' mandatory assignment law is patterned after Massachusetts legislation, according to Rep. McNamara. The U.S. Supreme Court allowed that law to stand, by refusing to hear a challenge to it. McNamara claims his bill isn't as stringent as Massachusetts', because it provides for no regulatory setup and depends upon the courts for enforcement.

But that means physicians could be dragged into litigation for any charge over what Medicare determines "reasonable," according to Dr. Johnson. "It's extremely onerous. And what's worse is that a physician in one county will be faced with charges of fraud for doing the same thing that's perfectly legal in an adjoining county designated as a "manpower shortage area," he says. "Physicians could be prosecuted in Illinois for charging amounts expressly permitted by the federal government."

Massachusetts Medical Society (MMS) Executive Vice President William G. McDermott, Jr., M.D., believes the mandatory assignment law there has produced multiple problems for one of the nation's most prestigious medical communities. According to a 1988 MMS survey he cited in the April, 1989 *Consultant*, "more than 85% of hospital heads interviewed reported that they are actively recruiting physician specialists. Of these, almost 90% are having problems attracting physicians needed to fill out their staffs. The MMS survey also shows a decreasing interest among doctors remaining in the state. Dr. McDermott notes that an earlier, 1987 survey of residents/fellows indicated "59% had hoped to remain in Massachusetts to practice when they first began their residencies. Our newer survey showed that the figure had dropped to 36% after they had been in training for a time and were closer to making these decisions."

In *Consultant*, Dr. McDermott recommends that society ask hard questions about medical care costs. "If we need state laws to protect the *less* fortunate," he says, "should these same laws also protect the *most* fortunate?"

Three other states besides Massachusetts have mandatory assignment laws. In all three, state lawmakers are seeking to further change the system. According to American Medical Association (AMA) data, the Vermont and Rhode Island legislatures are considering raising the means test, making more seniors eligible for automatic assignment privileges. Connecticut is considering legislation to expand its mandatory assignment law beyond physicians to cover all Medicare Part B providers. The AMA cites some ten other states looking at the issue this year. ▲

Mandatory Medicare Assignment Roll Calls

House Consumer Protection Committee (H.B. 402)

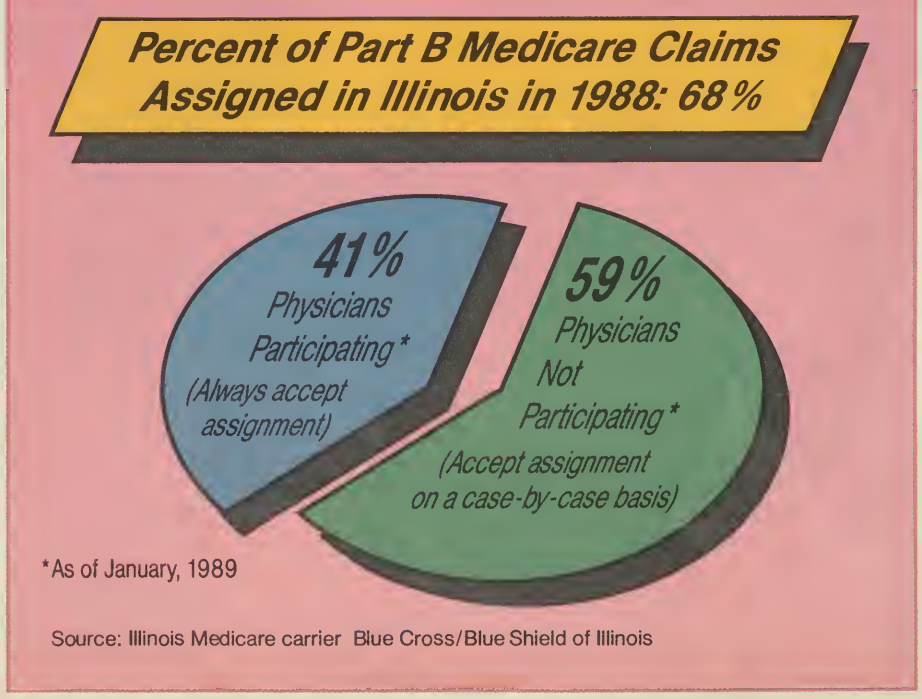
*Yes**	*No*
Lee Preston (D-Chicago)	Dick Klemm (R-Crystal Lake)
Arthur Turner (D-Chicago)	Margaret Parcells (R-Glenview)
Clem Balanoff (D-Chicago)	Terry Parke (R-Schaumburg)
John Cullerton (D-Chicago)	Bernard Pedersen (R-Palatine)
Monique Davis (D-Chicago)	Penny Pullen (R-Park Ridge)
Ellis Levin (D-Chicago)	
John Matijevich (D-Waukegan)	
Charles Morrow (D-Chicago)	
Phil Novak (D-Kankakee)	
Larry Woolard (D-Marion)	
Anthony Young (D-Chicago)	

Senate Judiciary Committee (S.B. 180)

*Yes**	*No*
William Marovitz (D-Chicago)	Carl Hawkinson (R-Galesburg)
Thomas Dunn (D-Joliet)	
Ethel Alexander (D-Chicago)	
Arthur Berman (D-Chicago)	
Howard Carroll (D-Chicago)	
John D'Arco, Jr. (D-Chicago)	

*favors mandatory assignment

Physician Facts



*As of January, 1989

Source: Illinois Medicare carrier Blue Cross/Blue Shield of Illinois

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On the Legislative Scene

Discipline . . . The Coalition on Consumer Rights, a self-styled medical consumer group, is behind legislation establishing a toll-free number at the Illinois Department of Professional Regulation (IDPR) to give out information on whether particular physicians have ever been or are currently "the subject of any disciplinary action." Sponsored by Rep. Lee Preston (D-Chicago), the bill failed by one vote in the House Consumer Protection Committee. ISMS opposed it, because IDPR already publishes disciplines and because information on disciplinary investigations should remain confidential until cases are decided.

Discrimination . . . Eliminating alleged discrimination against foreign medical school graduates is the stated purpose of H.B. 2684 which was jammed through the House Human Services Committee two weeks ago by Democratic leadership. But the bill may go much further according to medical legal analysts. It grants FMGs licensed in another state automatic reciprocity when seeking an Illinois license, regardless of whether that state's licensing standards measure up to Illinois'. Under the legislation, FMGs might also be able to claim civil rights violations when turned down for hospital medical staff privileges.

Optometrists . . . Legislation allowing optometrists to use prescription drugs in the diagnosis and treatment of eye disease became only a remote possibility this year, after the House Consumer Protection Committee moved H.B. 2211 to "interim study" status. Reps. E. J. "Zeke" Giorgi (D-Rockford), Frank Giglio (D-Calumet City), Bob DeJaegher (D-East Moline) and Ellis Levin (D-Chicago) were sponsors. ISMS worked with the Illinois Association of Ophthalmology to strongly oppose the bill, based on optometrists' lack of the necessary medical education and training to diagnose and treat eye disease.

Indigent care . . . An Illinois Hospital Association-backed bill attempting to address part of the uninsured/underinsured—or, medically indigent—problem cleared the Senate Executive Committee only to land on the Secretary's desk because of the Senate's leadership dispute. The Secretary's desk is a sort of limbo where most major legislation is residing until the dispute is resolved.

The bill encourages employers to purchase low-cost health insurance for their employees. Firms with five or more employees working 17.5 hours per week for three consecutive months will be required to provide a minimum benefit health package or pay a tax equal to the amount of those minimum benefits. Many business groups oppose the legislation.

Meanwhile, Governor Thompson on April 25 convened a health care "summit" comprised of legislators, health care executives, public health officials, insurance representatives, and business and labor leaders to focus on funding care for the medically indigent, ensuring access to quality care for both urban and rural residents, improving Medicaid reimbursement systems and marketing Chicago as world-class medical center. The summit is scheduled to report its findings in late May.

U of I . . . Two bills authorizing University of Illinois/Cook County Hospital affiliation agreements have cleared the House Higher Education Committee. According to Cook County Board president George Dunne, the legislature must act before the board will consider the agreements, which include the county's proposed lease of the 500-bed university hospital. Implementation of the county agreements is necessary to ensure that the university's proposed affiliation with Michael Reese Hospital and Medical Center goes through smoothly.

Public health immunities . . . A bill immunizing from liability physicians who sign standing orders and review protocols for IDPH-designated public health clinics cleared the House Judiciary I Committee May 4. ISMS supports the legislation.

Medical staff . . . Legislation granting hospital medical staff membership to chiropractors was defeated in committee. Currently, hospitals may use the services of chiropractors, but cannot grant them medical staff membership because Hospital Licensing Board rules only allow membership for MDs, osteopaths, dentists and podiatrists. ▲



Photo: Ron Ackerman

Deputy Governor Jim Reilly kicks off the indigent care "summit" meeting. ISMS Executive Vice President Alexander R. Lerner represented the medical society.

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

SEMINAR SCHEDULE

Health Care Service Corporation (Blue Cross and Blue Shield of Illinois) has scheduled Back to Basics Seminars for Blue Shield and Medicare Part B for medical assistants to be held during May, June and July 1989. There will be two sessions each day (unless otherwise noted) with each session addressing topics to include: Blue Shield Eligibility and Benefit Verification, Group and Policy numbers; Medical Services Advisory, Mutual Participation Program, Preferred Provider Option Program, General Billing Instructions for Blue Shield and Medicare B including CPT/HCPCS coding plus ICD-9-CM coding and a Medicare Part B general review.

Attendance is recommended for newer/less experienced staff personnel.

Invitations were sent in early April. Dates and locations are listed below:

May 02, 1989	(AM Only)	Quincy
May 03, 1989		Peoria-North
May 10, 1989		Chicago
May 11, 1989		Chicago
May 17, 1989	(AM Only)	Danville
May 18, 1989		Champaign
May 24, 1989		Chicago
May 25, 1989		Chicago
May 31, 1989		Elgin
June 01, 1989		Rockford
June 07, 1989		Joliet
June 08, 1989		Chicago
June 14, 1989		Moline
June 21, 1989		Park Ridge
June 22, 1989		Mundelein
June 28, 1989		Naperville
June 29, 1989		Naperville
July 11, 1989		Collinsville
July 12, 1989		Springfield
July 18, 1989		Carbondale
July 19, 1989		Mt. Vernon
July 26, 1989		Matteson

Reminder — ICD-9 CM Coding

ICD-9 CM coding on Medicare claims, or bills submitted to Medicare beneficiaries, became required for items and services furnished after March 31, 1989. Assigned and non-assigned claims submitted without the required information will result in letters to the physician for the proper diagnosis codes.

(This report is a service to the physicians of Illinois)
5/11/89

Editorials

Mandatory assignment law is here unless we act

Every physician must heed this alert if mandatory assignment legislation is to be averted. Separate bills have quickly advanced from Illinois House and Senate committees and await action by the full legislature. Our response is critical. Contact your legislator today and tell him or her—in no uncertain terms—how mandatory assignment will affect patient care in Illinois. Remember that when constituents talk loudly and courteously enough, legislators listen. Otherwise, we'll have to live with the uncomfortable consequences of silence.

Thwarting the "grapevine"

AIDS virus testing generates social dilemmas. That's the message of the AIDS Confidentiality Act. As physicians, we must be ever mindful of the patient's right to privacy, because of the negative chain reaction that release of HIV testing information can cause. For instance, billing insurers for HIV tests, without the patient's express consent, could result in insurance cancellations or denials. And medical records containing HIV testing information could become grist for the "grapevine" if not carefully guarded.

The law rightfully allows for release of HIV test information to health care workers who need to know. But, this information must be handled with care. As physicians, we know the importance of responsible management of sensitive patient information—lessons we've learned through treating substance abuse, mental illness and other medical problems that carry social stigmas.

We need to provide the benefit of our leadership and experience to nonphysicians involved in the diagnosis, treatment and care of AIDS patients. Only then can the highest standards of patient confidentiality be maintained.

A necessary partnership

The public furor stirred by antivivisectionists on using animals for biomedical research continues. ISMS believes man's partnership with animals must thrive, if the remaining mysteries of disease are to be solved. Computers simply cannot substitute for animal models. One lesson of the dispute is very clear—public education on the importance of animal research and the medical profession's dedication to humane treatment of animals must be stepped up. This is one argument medicine—and society—can't afford to lose. ▲

Illinois Medicine

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Guest Editorial

The physician's office staff: important ambassadors



Michael H. Cohen

by Michael H. Cohen

Positive—or negative—interactions with the physicians' office staff have a significant influence on patients' perceptions and opinions about the physician. Consider: Do your receptionists and staff treat patients with a demeanor of professionalism and sensitivity that casts a positive reflection on you? Or, do they practice TDC (Thinly Disguised Contempt) toward patients, on the telephone and in the office?

Many physicians are taking positive steps to improve the quality of patient relations in order to retain current patients and attract new ones in today's competitive health care market. These enlightened practitioners understand that the patient must be viewed, from one perspective, as a consumer with choices, and that he or she selects a physician on the basis of non-technical criteria. The patient simply expects to be treated by the physician and the office staff with courtesy, respect and empathy. Most importantly, patients want and expect a "user-friendly" environment with office procedures and staff attitudes that facilitate access to the physician.

Let's look at some of the most common examples of patients' upsets. They don't like lengthy sessions in the physician's waiting room without explanation or apology from the staff. Patients also resent hearing the doctor's office staff—or the doctor—discussing personal information about patients within earshot of others. Patients also say they need more privacy when billing arrangements and other financial matters are discussed with them at the doctor's office.

As a physician/practice manager, your responsibilities include:

- Establishment of an office environment which exemplifies good patient relations and the working ethic that the "patient is king."
- Communication of this attitude to office personnel with a commitment that signals you mean business.
- The expectation that your staff take ownership of the process, and that they commit themselves to service excellence.
- Translation of the goal into behavioral expectations, so that employees know specifically what they should say and do to enhance patient relations.
- Creation of a "user-friendly" system. Conduct an audit of your office procedures to assess whether you are currently making it easy for patients to access and pay for services. Ask your patients what you and the staff can do differently to make contact with your office a more pleasant experience whether by personal visit or by telephone.
- Hiring and training only those people who enjoy being helpful to others, and who place friendly attitude and service as a top priority. Remember that you have a major responsibility as a role-model. Don't fall victim to the "Do as I say, not as I do" syndrome.
- Evaluation of your employees based on interpersonal skills. How they relate to patients and visitors is every bit as important—and perhaps more important—than their technical skills alone. Patients unfailingly recognize when they are being treated with discourtesy.
- Investment in your employees by providing them with training and development opportunities on how to improve their patient relations skills. Many good educational workshops and programs specializing in these areas are available, such as those sponsored and conducted by The American Association of Medical Assistants, and other organizations.
- Prompt dismissal of employees who lack the will or skill to practice positive patient relations.

Employees can be outstanding public relations ambassadors and representatives for your practice. The relationship your staff develops with patients will help determine whether or not patients maintain their allegiance and recommend you to others. Another side-benefit of building good patient relations into your practice: patients seem to pay their bills more quickly when they are satisfied with the personalized care and attention they receive from the physician's office staff. Attention to patient relations as a management responsibility pays off! ▲

Mr. Cohen is a nationally recognized consultant and workshop leader, specializing in management development, organizational communications and employee relations. He has taught courses in organizational behavior, interpersonal communications, group process and management effectiveness at area universities, and he has written numerous published articles as well as a book entitled On-The-Job Survival: A Guide for Dealing With Everyday Work Problems.

Letter to the Editor

Mandatory Assignment

I was dismayed to see the lead story in the March 17, 1989 issue of *Illinois Medicine* which reported that "Mandatory assignment (is) back in the hopper." If this bill, which is being sponsored by Rep. Anthony Young (D-Chicago), Sen. William Marovitz (D-Chicago), and Rep. John McNamara (D-Oak Lawn) becomes law, another block in the structure of the once strong patient-physician relationship will have been destroyed. Why should not patients and physicians have the right to enter into a relationship for services to be provided by one and for remuneration by the other just like any other people in a business relationship do?

The powers that be—government, insurance companies, etc.—are forcing us to carry on our practices in a more business-like manner. If they want us to be more business-like, why do they not want us to be able to enter into contracts with Medicare beneficiaries?

Whether or not Medicare assignment should be accepted is a matter best left for physicians and their individual patients to decide. The fact that the initial Medicare legislation provided two options (accept assignment or do not accept assignment) indicates that the Medicare program does not deem assignment mandatory.

Senior citizen groups will have us believe that those who are Medicare beneficiaries deserve special financial considerations because they are less well off than the population as a whole. But this is not the case. Whereas, when the basic Medicare Act was enacted in 1965, the poverty rate among the elderly was 28.5% (just more than double that of the nonelderly), it now has decreased to 12.2% (a bit better than the 13.7% rate of the nonelderly). From an economic perspective, the elderly are on a par with the nonelderly. Age alone should not grant special prerequisites regarding payment for health care.

The fact that slightly more than two-thirds of recent Medicare claims filed in Illinois were on an assigned basis indicates that Illinois physicians are willing to accept assignment on a case-by-case basis.

This issue of mandatory assignment points out again that physicians must be active in the political process because the results of that process have a profound effect on our lives. Please write to your state legislators and ask them not to support this bill.

George Goldstein, M.D.,
President,
Lake County Medical Society

Point/Counterpoint

The use of animals in research continues to provoke controversy between the public and scientific communities. Illinois Medicine *invited two spokespersons from opposing sides of the issue to present their views.*

The question: Should animals be used in medical research?

An Affirmative View



by Donald O. Nutter, M.D., Senior Associate Dean, Northwestern University Medical School, Chicago

The origins of the present tensions between research institutions and antivivisectionists can be traced back to the late 19th century. It was then that research began to play an important role in medicine and the antivivisectionist movement began in earnest in Victorian England.

Since then, medical research and the use of experimental animals has grown enormously and produced more modern-day medical "miracles" than anyone in the 19th century could have foreseen. At the same time, governments and research organizations have become much more sophisticated in regulating the humane treatment of animals. Northwestern University research is conducted in accordance with federal laws and regulations, including those of the U.S. Department of Agriculture, under the provisions of the Animal Welfare Act, the U.S. Public Health Service, and the National Institutes of Health.

Despite compliance, Northwestern, one of the nation's leading research universities, is now being subjected to antivivisectionist tactics that are unforgivable in this modern day. Five researchers on our Evanston campus, in particular, have been targets in a campaign of misinformation and distortion of their scientific research by animal rights activists.

The work of two of the targeted Northwestern researchers is contributing to the early diagnosis of diseases, such as glaucoma, that are among the major causes of blindness in this country. Their work has contributed significantly to the development of tests used in assessing the consequences of and recovery from strokes and related disorders.

Another Northwestern scientist's research that attempts to understand how oxygen is used in the retina has direct relevance to many blinding diseases.

The fourth researcher is making important contributions to our understanding of abnormal brain circuits underlying epileptic seizures.

The fifth scientist is conducting essential studies of how the brain controls speech; 22 million Americans suffer from speech disorders caused by stroke, Parkinson's disease and other illnesses.

Animal models of human disease have advanced our understanding of major social problems such as alcoholism, and have produced treatments for everything from mumps to manic-depressive illness. Vaccines developed through animal research have virtually eradicated diseases like smallpox and polio. Some of these vaccines, it is interesting to note, are also widely administered to animals to protect their well-being.

Advances in medicine dictate that the nation's scientists must continue their quests for knowledge through biomedical research. It is inordinately unfair that in the process such fine researchers as those targeted at Northwestern are being portrayed as immoral or cruel people with little to contribute to science. Nothing could be further from the truth.

Their work, and the work of other dedicated researchers, must continue. If biomedical research is severely retarded or halted as a result of a citizen minority who oppose the carefully controlled use of animals in research, we will lose the battle against diseases and illnesses that afflict millions of people worldwide. ▲

An Opposing View



by Kay Sievers, Chicago Director, Trans-Species Unlimited

Whether or not experiments on nonhuman animals "work" . . . isn't the point. Some of the greatest social evils in our history "worked," and often very well.

Blacks were once hunted down and captured in Africa, shipped like livestock to America, enslaved, exploited, bred, brought and sold to provide cheap labor. And that "worked." Their suffering, exploitation and abuse built businesses and fortunes for their masters. But it wasn't right.

Women, children, and minorities were savagely exploited to run the great wheels of the industrial revolution—in the mines, in the sweatshops, building railroads—working for subsistence wages. Their suffering, exploitation and abuse built businesses and fortunes for their employers. But it wasn't right.

And, American Indians had the often fatal misfortune of occupying the land that enterprising settlers wanted for themselves. So these "savages" were systematically slaughtered or rounded up, and shipped to reservations by the technologically superior pioneers and founders of this country. Their suffering, exploitation and abuse built a nation and made fortunes for their conquerors. But that wasn't right, either.

The human animal has a long history of justifying any injustice we perceive to be in our own selfish interest.

Today we abuse and exploit nonhuman animals, using rationalizations that have been used against every other abused and exploited race, sex, age, religion or culture: "They're not like us. They don't act, speak, think, look or live like us. They're here for us to use . . . for our benefit and convenience."

We all have a place in this world. We are all tied together in a mutually interdependent web of being. Our fatal flaw is our lack of awareness, our failure to care for, respect and connect with the rest of the earth and other life forms. With our great intellectual "superiority", scientific methods and advanced technology, we have still failed to understand that this earth and all her inhabitants are an interconnected, integrated, mutually interdependent whole. We have become a sick society—sick mentally, sick spiritually, and sick physically.

When we demand rights for nonhuman animals, we're not asking that they be given the right to vote, or receive equal wages. Non-human animals have no interest in those things. But we all, human or non-human, share a basic common heritage. We feel pain. We give birth to and value and care for our offspring. We have our own methods of communication and social structure. We all deserve the freedom to go our own way, make our own life choices.

Those are the rights we all—human and non-human—value and deserve. When we deny those rights to other living, sentient beings, then we also deny a part of ourselves. We become callous, and closed, selfish and violent. We set ourselves up as little gods. No need is as valid, no pain is so sharp, no desire is so impelling as our own, no matter what the cost to others, no matter what the cost to ourselves. We sell our souls to avoid pain and death. We become the "other," cut off from our roots, our better selves, and the world. We become morally and spiritually repugnant, willing to "sacrifice" any life, inflict any pain—as long as it isn't our own. ▲

JUAs no panacea for malpractice insurance, say other states

by Eileen Norris

THERE IS only one acceptable reason for starting a Joint Underwriting Association (JUA) for medical malpractice insurance, says the executive director of the Massachusetts JUA, which is currently running $430 million in the red.

And that reason? "There has to be no other place to get coverage," says Richard W. Moore.

It's unacceptable to start a JUA just because one believes insurance rates are too high or that they will magically get lower through the JUA, he adds. "It just doesn't work that way," says Moore, who nevertheless defends the Massachusetts JUA for one simple reason: "When insurers pulled out of this market, we had no other choice."

In Massachusetts, the JUA is the only game in town, says Martin J. Hatlie, senior counsel for the American Medical Association.

"Physicians employed with large universities and hospitals can get coverage through their employer but the typical doctor in Massachusetts doesn't have a choice, so in that case, we're glad the JUA is there," says Hatlie.

JUAs: government-run insurers

Most agree that these insurers of "last resort," with rare exceptions, generally do not work very well, especially over the long run. JUAs provide insurance much like commercial firms and physician-owned companies, but state statutes preclude the pools from withdrawing from the market, even if rate increases are scaled down or denied.

JUAs typically are government-run. They began as temporary answers to the volatile medical malpractice market of the mid-1970s, when some 20 states created these joint risk pools in response to commercial carriers fleeing the market.

Property/casualty insurers operating in a state with a JUA are required to join the association, which establishes a rate structure and offers coverage to all health care providers at those rates. If income generated through collected premium is too low to pay claims, the amount is made up from assessments to the JUA members. That's why insurers, many of whom don't even write medical malpractice, don't like paying out for claims they had nothing to do with.

The situation in other states

Physicians in New Jersey know all about that. Although the JUA disbanded in 1982, after a physician-owned company had started up and commercial insurers had begun to write coverage, all physicians in that state are currently being assessed a 4 percent surcharge on their medical malpractice premiums to pay for 10-year old claims they had nothing to do with. And New Jersey actuaries think another $60 million will be needed to pay claims filed over the next decade.

"Our situation is not all that different from New Jersey," acknowledges Moore of the Massachusetts JUA. "If we stop writing business today, we might come to that point, but we're still getting premium dollars in and we just have to hope that our claims experience will continue to stabilize as it has for the past three years." Still, he concedes, "we are putting off the day of reckoning."

Although a number of JUAs have disbanded, the deficits of the remaining dozen have skyrocketed, according to the Alliance of American Insurers, a trade association of 170 property/casualty insurers based in Schaumburg.

A recent Alliance study reports that JUAs in Massachusetts, New Hampshire, New York, Rhode Island and South Carolina have racked up an aggregate deficit of nearly $1.5 billion.

Of the 12 active JUAs, seven are in serious financial trouble, says Roger J. Kenney, senior research manager for the Alliance and author of the study which analyzed the 1987 operations of the JUAs.

Those seven include Massachusetts, New York (those two are thought to be in the worst shape,) Rhode Island, South Carolina, New Hampshire, Florida and Kansas. JUAs in Texas, Pennsylvania and Wisconsin are faring better, and JUAs in Minnesota and Virginia are too new to analyze.

What's happening in Illinois

Many states, including Illinois, rely on commercial carriers and doctor-owned insurance companies, such as the Illinois State Medical Inter-Insurance Exchange (ISMIE). About 44% of the state's physicians, or 9,500, are insured through the company, which was started in 1976.

"In Illinois, availability of coverage is not a problem for the vast majority of physicians," adds Hatlie.

"Illinois shouldn't start a JUA because there's not an availability problem here," he says. "And frankly, if a physician can't get coverage with ISMIE or the two carriers in the state, there's probably a good reason for that. He or she is probably judged to be less than desirable because of claims history."

How it's working in Wisconsin

In neighboring Wisconsin, the JUA appears to have sufficient invested assets to cover existing losses, the Alliance report says, but that too could change. The Wisconsin Health Care Liability Insurance Plan, or WHCLIP, considers itself and its physician members to be on the conservative side, says Gerald Peura, the JUA's claims manager.

"Wisconsin is conservative from a litigation standpoint as well," he says. Still, he warns against starting a JUA in hopes of getting lower rates. "It's one thing if the market isn't there and there's an availability problem," says Peura.

"Here in Wisconsin if the market is good and competitive the number of physicians and hospitals we insure goes down. If availability is scarce, our insureds go up," he points out. The JUA insures about 25% of the physicians and hospitals in the state.

JUAs and their future

The real problem for JUAs may be longevity, since they seem to profitably thrive for the first five years of their existence with low premiums and, not surprisingly, happy members.

But eventually the claims begin to roll in and it becomes clear that "no one in this business gets something for nothing," says Mary Belgrade, executive secretary of the National Coordinating Committee on Medical Malpractice JUAs. Belgrade is an attorney and assistant vice president of government affairs for the Alliance.

"As far as I am concerned, there is no condition under which a state should start a JUA," she asserts. "Ultimately, they are losers and common sense tells you that if a commercial insurance carrier could write business favorably in the state, they would do it."

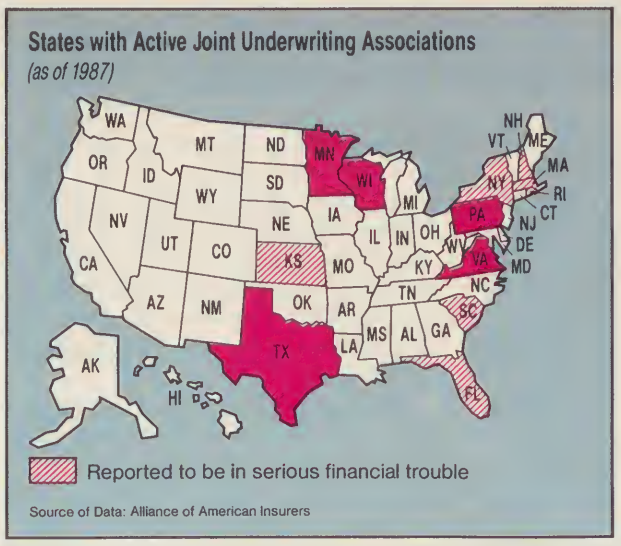
"JUAs become a public problem because as physicians and other providers are assessed to pay for their deficits, we all pay for it as physicians, hospitals and insurers have no choice but to pass their increase along to the public," she adds.

Texas: The 'lone star'

The only JUA thought to be in pretty good financial shape is in the state of Texas, says Kenney of the Alliance, where rates are adequate and every year starts over at level ground. "They run the business for the year, evaluate it and make appropriate adjustments to the rate," says Kenney, who hastens to add: "That's the way they (JUAs) should be run."

The problem with most JUAs, he continues, is that they charge the policyholder of the future to pay for the losses of the preceding generation. "In essence, it's similar to the mess the social security system is in. What we pay for today goes to retired people. One has to wonder what money will be there where the current generation is of retirement age."

"It's the same with most JUAs, because the premiums paid today in Massachusetts, New York and Rhode Island are being used to pay for old claims. Eventually, they will run out of money. It's pushing off that day of reckoning," he adds. ▲



JUA 1987 Market Share

State	*Percent*
Florida	10.4
Kansas	5.9
Massachusetts	84.5
Minnesota	0.4
New Hampshire	52.5
New York	14.3
Pennsylvania	3.4
Rhode Island	75.1
South Carolina	53.7
Texas	9.9
Virginia	2.8
Wisconsin	46.8

Includes all health care providers (not limited to physicians)

Source of Data: Alliance of American Insurers

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—A 28-year-old woman, pregnant with her second child, was admitted to the hospital at term with mild uterine contractions. About five hours later, her bag of water ruptured and nurses soon noted signs of fetal distress.

The case in brief—The physician who had cared for the woman during her pregnancy advised her to go to the hospital when she telephoned to say that contractions had begun. After she was admitted, he telephoned the hospital to check on the progress of her labor. Although the physician treated the patient for high blood pressure during her pregnancy, no other unusual problems were noted before labor began. Her first pregnancy and delivery had been normal. About five hours after admission, the patient's bag of water ruptured. Shortly afterward, nurses monitoring the patient noted deceleration of fetal heart tones. The physician was called and informed of the problem. When he did not arrive within a few minutes, nurses made two additional telephone calls to tell him the fetus was experiencing difficulties. Fifty minutes elapsed before the physician arrived and the delivery took place. At birth the infant was anoxic with the cord wrapped around its shoulders. Although oxygen and extended cardiac massage immediately were administered, it was several

Case In Point

(continued from page 6)

minutes before respiration could be sustained. Apgar scores were low. A pediatrician who examined and treated the infant shortly after birth ordered immediate transfer to a nearby hospital with facilities for treating high risk neonates. However, the baby girl had suffered severe brain damage and would require care throughout her life.

The resulting claim—The parents sued the physician who delivered the child, the consulting pediatrician and the hospital (on behalf of the nurses involved) for delay in arranging and attending the birth and for deviation from the standard of care, resulting in the birth of a severely brain-damaged infant.

The outcome of the claim—The pediatrician was dismissed from the case. The physician who delivered the infant and the hospital settled the case for a total of $550,000.

Why problems arose with this case—The basic reason the case was not defended is that the delivering physician was deemed too slow in responding to the calls from nurses informing him that the fetus was in distress. Consultants agreed that this delay substantiated the allegation of deviation from the standard of care. The possibility that the infant's brain damage might have been prevented or at least minimized by quicker action could not be overlooked.

The points this case makes—The physician argued that the nurses had not indicated strongly enough to him that an emergency was developing. The nurses insisted that they had so informed him. What this case demonstrates is a severe break-down in communications with a tragic outcome.

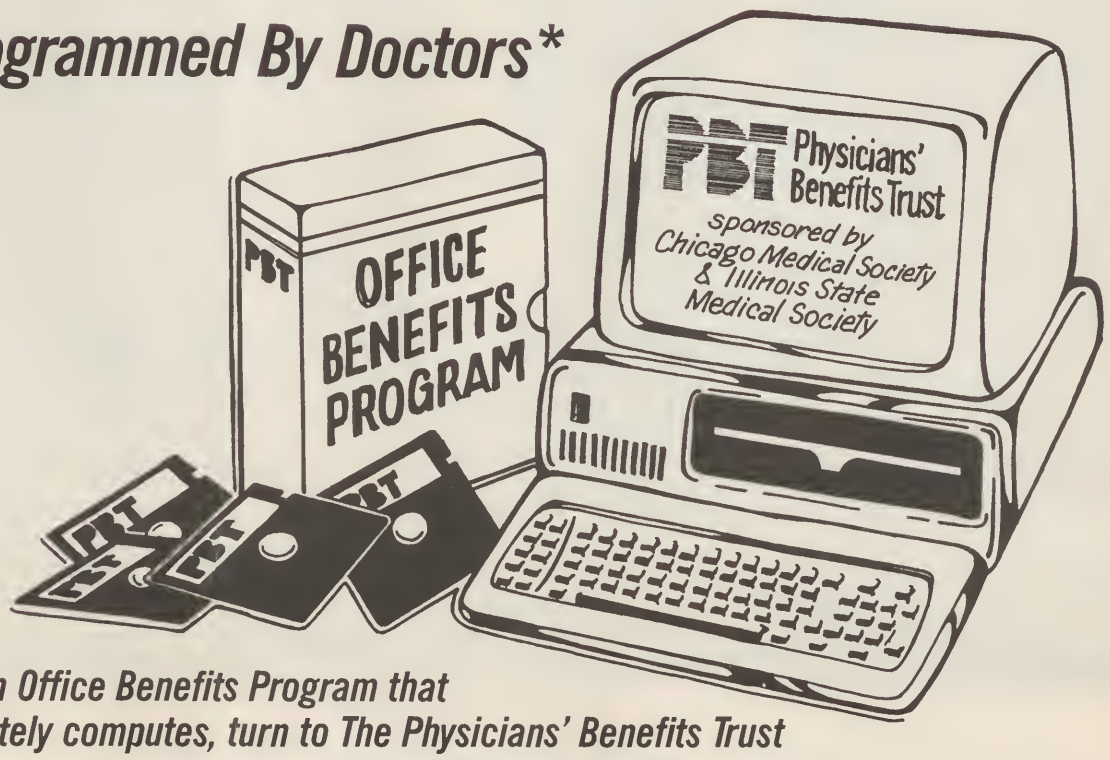
Unfortunately, such short-circuits in the vital links between physicians and hospital personnel are far too common. Consultants offer these suggestions to physicians for keeping communications lines open and information flowing freely:

- —Develop good rapport with nurses and other hospital personnel;
- —Encourage calls and reports of any changes in a patient's condition that could be significant or indicate a developing problem that requires attention;
- —Alert nurses to potential problems;
- —Create a climate in which nurses feel free to call with information about a particular patient's condition. Some physicians convey so much displeasure at being called by nurses that these key observers hesitate to pick up the telephone to relay what may be critical information until they are sure that it is critical. Physicians performing deliveries, however, are more accustomed to calls from hospital labor and delivery nurses at all hours, reporting that a patient is about to deliver, and often have good rapport with the nursing staff;
- —When a nurse calls with information, listen closely. Ask questions. Try to understand exactly what the nurse is saying. In court, the testimony of a physician that the nurse's call did not indicate that a patient was developing problems may conflict with that of the nurse who earnestly says, "But I told him it was an emergency." The nurse's statement may also be documented in the nursing notes;
- —If a nurse calls reporting a significant condition change in a patient, respond promptly. Delay in responding is a powerful factor weighing against a physician if he or she is sued;
- —Finally, if a nurse does not call, don't assume that everything is all right. Check back yourself. Call. Revisit the patient. Or delegate follow-up in the interim to another physician who is in the hospital.

Suits against both hospitals and treating physicians alleging that the physician did not pay sufficiently close attention to nurses' warnings of a patient's deteriorating condition are frequent. If this can be shown, the physician is liable.

The liability is not always that of the physician. "In a great many cases, during the trial the evidence shows that what actually happened is that the patient became worse very suddenly, and the hospital staff nurses either did not realize it, or knew it but did not phone the physician to come back to see the patient. Since knowing when to call the physician is part of the due care, skill and knowledge expected of a nurse, in this situation the hospital is vicariously liable for failure to meet that standard, and the physician is not," wrote Angela Roddey Holder, in her book *Medical Malpractice Law*. The most common allegation against nurses who are sued is failure to promptly recognize and report condition changes, contributing to a delay in treatment. ▲

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(continued from page 1)

empted from obtaining *written* consent, but only when the HIV test is medically indicated and the patient has otherwise consented to treatment. Physicians still have an ethical duty to gain a patient's *informed* consent—albeit not written—for *any* diagnosis and treatment, and to scrupulously guard patient confidentiality.

The Illinois AIDS Confidentiality Act stipulates that information regarding HIV testing may be released only to the patient, his or her authorized representative, or medical or public health workers who have an expressed need to know about a patient's HIV status. It consequently imposes on physicians a duty to keep orders for HIV testing, test consent forms and test results strictly confidential.

Protecting patients from discrimination

The law acknowledges that it is not only the disclosure of HIV test results but disclosure of the act of testing itself which may have devastating effects. John Hammell, director of the AIDS and civil rights project of the Illinois American Civil Liberties Union, Chicago, notes that mere performance of an HIV test "can identify a person in someone's eyes [as being] at risk of HIV infection or AIDS, and there have been instances of discrimination because of that."

The statute also takes into consideration the significant psychological impact that HIV testing may have on individuals. "Testing for HIV antibodies is like testing someone for Huntington's chorea. The test implies you have an incurable disease, which will ultimately be degenerative and lead to death. So this test can have a profound effect on a person's view of his life and his future," says Ken Haller, M.D., an East St. Louis pediatrician and chairman of the St. Clair County Task Force on AIDS.

The 1988 amendments to the act do not alter physicians' responsibilities to maintain patient confidentiality. The amendments "in no way change [these] provisions of the original AIDS Confidentiality Act," says William Shurgin, partner in the Chicago law firm Seyfarth, Shaw, Fairweather, and Geraldson.

AIDS testing without written consent

The 1988 amendments describe the circumstances under which a physician may order a test without obtaining written informed consent. Specifically, they allow physicians to order HIV testing without written informed consent when (1) the physician judges that HIV testing is medically indicated to diagnose or treat a patient and the patient has otherwise consented to treatment by the physician; and (2) a health care professional or employee, a firefighter, or an emergency medical technician is exposed to blood or body fluids and the exposure may transmit HIV.

The amendments, however, may cause confusion among physicians, Shurgin states. For one thing, he points out, "some physicians may view [the law] as a right to undertake an HIV test without consent whenever they want to, which is not what the statute says."

As interpreted by the Illinois Department of Public Health (IDPH), the amendments do not permit standing orders to test every patient for HIV antibodies. In light of other related Illinois statutes giving patients the right to refuse treatment, physicians should not order an HIV test for any patient who objects.

On the other hand, the amendments do not describe precisely when an HIV antibody test may be considered medically necessary. IDPH suggests that the decision to test without written informed consent must be made on a case-by-case basis, based on an individual patient's medical history or physical findings. These findings should be documented in the patient record.

Health care institutions can and have decided to require written consent, regardless of the exemption in Illinois law. Hospital medical staffs could face this question in the future, and may want to decide for themselves on whether or not to advocate written informed consent for HIV testing.

Preserving confidentiality: the physician's role

Illinois physicians need to establish procedures for preventing inappropriate disclosures of information about individuals undergoing testing, for counseling patients about the test and its implications, and for documenting when and why testing is done without written informed consent.

Under Illinois law, physicians may incur criminal penalties of $500 in fines and three days to six months in jail, or civil penalties of $1000 for violating the confidentiality of patients undergoing HIV testing. If breaches of confidentiality are reckless or intentional, fines may reach $5000.

"Physicians need to set up procedures to guarantee confidentiality that cover them, their staffs, and anyone who works for them. They should set up and maintain a record-keeping system that also guarantees confidentiality," says Nancy Ford, director of the Center for Legal Studies, Sangamon State University, Springfield.

According to Ford, physicians should establish policies that govern the confidentiality of all medical records in the office, including when medical information is disclosed to other parties, how disclosures are documented, when and how patients may gain access to their records, and how office staff are trained to handle medical records.

Specifically regarding HIV testing, physicians should establish policies for:

- identifying those individuals who may receive the HIV test results. The Illinois AIDS Confidentiality Act allows disclosure of HIV test results to the patient or the patient's authorized representative; any person designated by the patient or his or her legal representative; referring, treating, or consulting physicians or the agents of an authorized health care facility or provider; the state or local health department; a facility or

(continued on next page)

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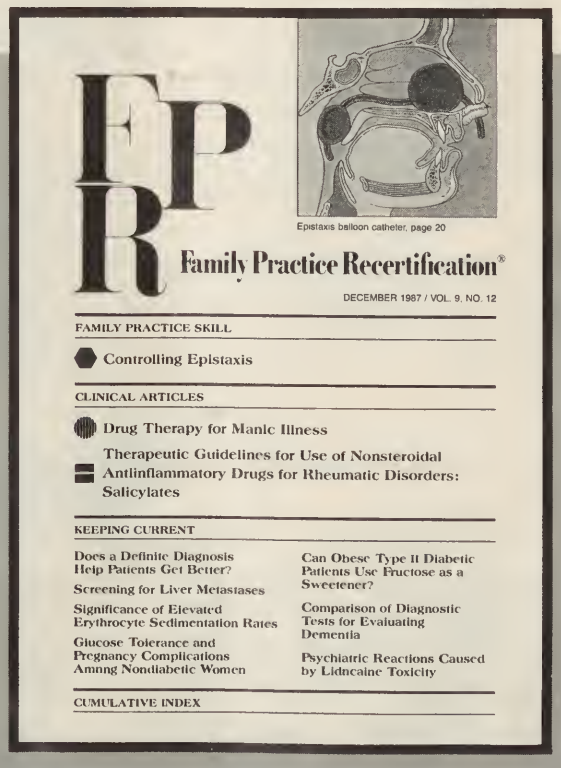
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provider involved in artificial insemination; and persons who have obtained a court order.

- determining which health care professionals have a need to know the identity of a patient who has had an HIV test or the test results. IDPH considers that referring, treating, or consulting physicians and agents or employees of a health care facility or provider have a need to know about a patient's HIV testing when (1) they are directly involved in patient care or in handling or processing blood and body fluids; and (2) they have come in direct contact with blood or body fluids in a manner which may transmit HIV.
- handling disclosure of information to third-party payers. Disclosure of information regarding HIV testing to payers is not permitted under the AIDS Confidentiality Act. Physicians consequently cannot bill a payer for an HIV test without a patient's express authorization.
- maintaining the confidentiality of medical records. Written informed consent, orders for the test when written informed consent is not acquired, and actual HIV test results must be kept confidential. IDPH stresses that any procedure for maintaining HIV test information in patients' medical records be uniform and consistent so records with HIV antibody test results cannot be distinguished. One procedure would create a separate sealed portion in all medical records and restrict access to it. Another would create separate, locked files for HIV antibody test information, similar to those for substance abuse or mental illness.

AIDS counseling and information

Physicians will have to provide certain information before ordering an HIV test. This includes the nature of the test and the meaning of its results; the nature and availability of further or confirmatory tests; and the availability of counseling services. While such pre-test information and counseling are not required by law in instances where written consent is waived, AIDS experts agree that discussion of treatment and testing is an essential part of the physician-patient relationship.

Except in "medically indicated" situations, physicians also will have to obtain written informed consent before ordering a test. Written informed consent, as defined in the AIDS Confidentiality Act, includes a fair explanation of the test, its purpose, limitations, the meaning of its results; and a fair explanation of the procedures that will be followed. ▲

AIDS brochure outlines M.D. responsibilities

The Illinois State Medical Society, through an Illinois Department of Public Health grant, recently developed a brochure explaining the practicing physician's responsibilities under the current AIDS laws.

The brochure is available through IDPH's AIDS Activity Section in Springfield. Call 217-524-5983. ▲

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

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CARAFATE (sucralfate) 1-gm tablets are supplied in bottles of 100 (NDC 0088-1712-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1712-49). Light pink scored oblong tablets are embossed with CARAFATE on one side and 1712 bracketed by C's on the other. Issued 1/87

Reference:
1. Eliakim R, Ophir M, Rachmilewitz D: *J Clin Gastroenterol* 1987; 9(4):395-399.

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(continued from page 1)

has also hit home at Northwestern University. One scientist has received death threats, and police don't know who's responsible for animal rights slogans spray-painted along three of the university's buildings. The Evanston-based Concerned Citizens for Ethical Research takes no responsibility for the occurrences. Over the last several weeks, that animal rights group has been picketing Northwestern for conducting five particular experiments which use research animals other than rodents. The animal rights group roundly condemns the university, claiming the animals are abused during experiments which have no benefit for humans.

David Cohen, Ph.D., Northwestern's vice-president of research vows the university will continue its research with animals. "There are a number of important biomedical research problems for which there is no alternative at this time to the use of animal models. Our research follows all federal standards and guidelines."

Scientists defend animal research

Medical experts defend biomedical research on animals as essential to saving human lives and curing disease. "The whole biomedical enterprise is built on the use of animals in biomedical research," says M. Roy Schwarz, M.D., assistant executive vice-president for medical education and sciences at the AMA. "You could not have had the medical breakthroughs from which we all profit on a daily basis without the use of animals. Our solution to AIDS and our understanding of Alzheimer's disease will also come from animal-based research."

Dr. Schwarz warns that the animal rights movement could put the future of biomedical research in jeopardy. "No one should underestimate the long term impact of the animal rights movement," he cautions.

He draws a distinction between "animal rights" and "animal welfare" groups. "On one hand, animal welfare groups are genuinely interested in relieving the suffering of animals. They do not want to ban the use of research animals. At the other end of the spectrum are many animal rights activists who are terrorists believing in threats and use of fire bombs. Their goal is to entirely eliminate the use of animals in medical research," says Dr. Schwarz.

Taylor Bennett, D.V.M., Ph.D., director of the biological resources laboratory at the University of Illinois in Chicago agrees that the future of biomedical research is coming under fire. "The end product of what knowledge we could gain by using animals in research is being diminished because of the increased cost of security we must provide and all the things that are evolving out of the current animal rights movement."

The Illinois State Medical Society (ISMS) has recently reaffirmed its position supporting the use of animals for medical research and education. Eugene P. Johnson, M.D., president of ISMS says, "While the welfare of animals is of deep concern to us, we also recognize what animal research has given to all whose lives have been saved. Animals are vital to the continuation of successfully treating and curing diseases fatal to mankind."

Activists state their case

Topping the list of why animal rights activists say they oppose the use of animals in research is that if these experiments are to benefit man, then man should be the subject of the tests. And according to some activists, this claim holds true even if it means sacrificing human lives.

William Witter, M.D., who practices pediatrics in Northbrook and Lincolnshire, is a member of Trans-Species. He calls most of today's animal research unnecessary and invalid. "To torture thousands of rabbits to save one human life . . . I have a hard time saying that that is necessarily a valid thing to do."

Lester Ichinose, Ph.D., a biologist at Barat College, Lake Forest, adds, "You're using intelligent animals that don't have the form of consent. The driving force for all biomedical research today is not the possibility for potential human benefit, it's for prestigious advancement in the scientific profession."

Public comments

A 1988 survey by the AMA polled the public on whether they believed the use of animals in medical research was necessary for progress in medicine. Seventy-seven percent of respondents said yes, 17 percent said no and six percent were unsure. More men than women thought the use of animals in research was necessary for advancement (83% to 72%). And more than 80 percent of college-educated people and those whose annual incomes are at least $30,000 believed that the use of animals was necessary.

Using animals to find cures

Scientists justify the use of species in biomedical research by the contribution animals have made in developing many treatments, cures and medications. One Chicago physician recalls the story of a colleague who developed surgery to help overcome the problem of blue babies. "Ninety percent of his first hundred cases, fifty percent of his second hundred cases, and ten of his third hundred cases all died," the physician relates. "The first two groups were animals. If he had to conduct those experiments on humans, there would have been significant loss before the technique was perfected."

Animals are also used today for teaching delicate surgical procedures and when alternative methods cannot be used in basic research, according to Donald Caspary, Ph.D., a Southern Illinois University (S.I.U.) professor of pharmacology who chairs the school of medicine's laboratory animal care and use committee. He and other S.I.U. researchers are using the animal called chinchilla laninger to study central auditory processing of information and the

(continued on next page)

Selected medical advances resulting from animal research

Pre-1900	Treatment of rabies, anthrax, beriberi (thiamine deficiency),and smallpox
	Principles of infection control and pain relief
	Management of heart failure
Early 1900s	Treatment of histamine shock, pellagra, (niacin deficiency) and rickets (Vitamin D deficiency)
	Electrocardiography and cardiac catheterization
1920s	Discovery of thyroxin
	Intravenous feeding
	Discovery of insulin—diabetes control
1930s	Therapeutic use of sulfa drugs
	Prevention of tetanus
	Development of anticoagulants, modern anesthesia and neuromuscular blocking agents
1940s	Treatment of rheumatoid arthritis and whooping cough
	Therapeutic use of antibiotics, such as penicillin, aureomycin and streptomycin
	Discovery of Rh factor
	Treatment of leprosy
	Prevention of diphtheria
1950s	Prevention of poliomyelitis
	Development of cancer chemotherapy
	Open heart surgery and cardiac pacemaker
1960s	Prevention of rubella
	Corneal transplant and coronary bypass surgery
	Therapeutic use of cortisone
	Development of radioimmunoassay for the measurement of minute quantities of antibodies, hormones and other substances in the body.
1970s	Prevention of measles
	Modern treatment of coronary insufficiency
	Heart transplant
	Development of non-addictive pain killers
1980s	Use of cyclosporin and other anti-rejection drugs
	Artificial heart transplantation
	Indentification of psychophysiological factors in depression, anxiety and phobias
	Development of monoclonal antibodies for treating disease

Source: American Medical Association

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Animal activists

(continued from page 10)

ototoxic effects of certain fairly-commonly prescribed antibiotics and anti-cancer drugs.

Noting the importance of animal research to develop drugs that will block the ototoxic effect of these agents, Dr. Caspary says, "Even the most sophisticated computer models combined with cell cultures do not approximate at this point what we've learned in animal experiments."

According to the National Association for Biomedical Research, 48 Illinois research facilities reporting under the federal Animal Welfare Act used approximately 108,000 animals in fiscal year 1987 for biomedical research. This number does not include experiments on rodents, which comprise some ninety percent of animals used in biomedical research.

Animal pain vs. medical gain

Animal rights activists insist that most animals used in research are abused and subjected to severe pain, sometimes deliberately. Robert Russell, M.D., director of S.I.U.'s microsurgery research unit responds, "Nobody likes to see animals suffer, but we are faced with unique problems sometimes and we couldn't possibly do these kinds of tests on people. We must use animals to find out whether the hypothesis is correct."

"Even the most sophisticated computer models combined with cell cultures do not approximate at this point what we've learned in animal experiments."

Five years ago, Dr. Russell and a team of researchers at S.I.U.'s medical school in Springfield conducted a biomedical experiment using pigs. Although unknown to them at the time, the knowledge gained from this research—how to close a nonhealing ulcer—would later save the leg of a 32-year old man who sustained multiple injuries from a motorcycle accident.

In 1985, the U.S. Congress set rigorous guidelines for the care and treatment of animals used in experiments. The Animal Welfare and the Health Research Extension Acts require the humane handling of animals, including minimizing pain and distress, providing a healthy physical environment to improve animals' psychological well-being, physical exercise for dogs and alternative methods of experimentation.

To ensure that these rules are followed, the U.S. Department of Agriculture (USDA) inspects each facility annually, with follow-ups where deficiencies exist. In addition, federally mandated animal care and use committees within research facilities, consisting of at least one veterinarian, one non-scientist and one person who isn't affiliated with the facility, monitor conditions.

Gale Taylor, D.V.M., Ph.D., director of laboratory animal care at the University of Illinois' college of veterinary medicine, Urbana, adds that "Inhumane treatment is not permitted. But for me to say that there isn't any pain involved, that's not true. Sometimes relief of pain is the object of the study so there is some distress. We certainly make every attempt to assure projects can stand very close scrutiny by the inspection committees."

More restrictions on the way

Animal rights activists are applauding even more stringent standards on animal care reflected in newly proposed USDA regulations currently up for public comment until July. According to the agency's animal and plant health inspection service, these proposed regulations would mandate more changes in animal facilities and cost nearly $1 billion to implement. More than half the cost would be paid for by research facilities.

Many animal researchers fear the proposed stricter guidelines, if implemented, will have a devastating impact on research institutions across the country. "I've been involved in this field for 25 years and I can assure you that this billion dollars is going to improve the health and care of animals very little. The bulk of it is going toward administrative tasks. We have facilities 50 miles from the campus, and when a committee of some 14 very highly paid faculty members devotes probably four or five days a year to inspecting animal facilities as opposed to doing research, that becomes a real burden," says Dr. Taylor.

Researchers at smaller animal research institutions share an even greater fear of these proposals' end results. Barbara Johnson-Wint, Ph.D, associate professor of biology at Northern Illinois University in De Kalb and chairman of the university's animal care and use committee, says Northern's research facility will have a difficult time staying in business if federal funds don't help meet the demands that the billion dollar price tag will have on them. ▲



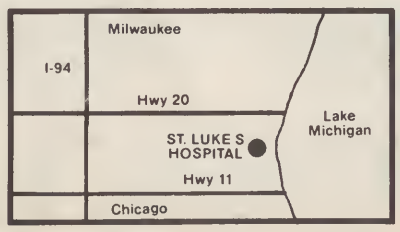
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Medicaid, licensure, discipline issues highlight ISMS forum



Photo: Partners, Inc.

Attendees at the April 12 ISMS Invitational Forum included (L) Richard Egwele, M.D., Chicago, chairman of the Association of Nigerian Physicians, and Eugene Anderson, M.D., Kankakee, president of the Illinois Society of Internal Medicine.

THE VOICE of physicians speaking to the Illinois legislature should be unified, and the Illinois State Medical Society (ISMS) should be that voice, said State Representative Alfred Ronan, (D-Chicago). Ronan's remarks came during an April 12 ISMS Invitational Forum for the leaders of other Illinois medical organizations. Other forum presenters included Stephen F. Selcke, Director of the Illinois Department of Professional Regulation (IDPR), Susan S. Suter, Director of the Illinois Department of Public Aid (IDPA), and Saul J. Morse, ISMS General Counsel.

Politics of health care legislation

"ISMS is respected in the Springfield arena, because your organization works year-round in the political process," Ronan said. "ISMS has achieved the success it has because you have staked out a position and spoken with one voice."

Ronan said there are several important health care bills this year: mandatory Medicare assignment; attempts by plaintiff attorneys to require prejudgment interest on damage awards; allied health practitioners' moves for independent licensure; and repeal of the mandatory AIDS test for couples about to marry.

In response to a question about the chances for passing a cap on non-economic damages, Ronan said he believes that political realities, including House Speaker Madigan's strong opposition, makes the passage of caps difficult this year. Ronan is a sponsor of the caps bill.

Licensure, discipline rules cited

IDPR Director Selcke pointed out two major changes in the licensure law as a result of the new Illinois Medical Practice Act. One change was a shift from a "programmatic review of a potential licensee's educational background, to individual review." Under the old law, Selcke said, if a physician graduated from an approved program, licensure approval was given almost automatically. Selcke said an amendment has been made to the new Medical Practice Act, supported by ISMS, to allow pre-1985 medical school graduates to be reviewed individually for licensure.

The other important change in the Medical Practice Act, according to Selcke, was the increase in licensure fees from $100 every three years, to $300 every three years. This has allowed IDPR to have two medical directors, one in Springfield and one in Chicago, and to increase the department's number of medical investigators and attorneys. Selcke said investigators should have a professional approach and demeanor, and he urged physicians who encounter investigators not acting professionally to contact him.

Public aid initiatives detailed

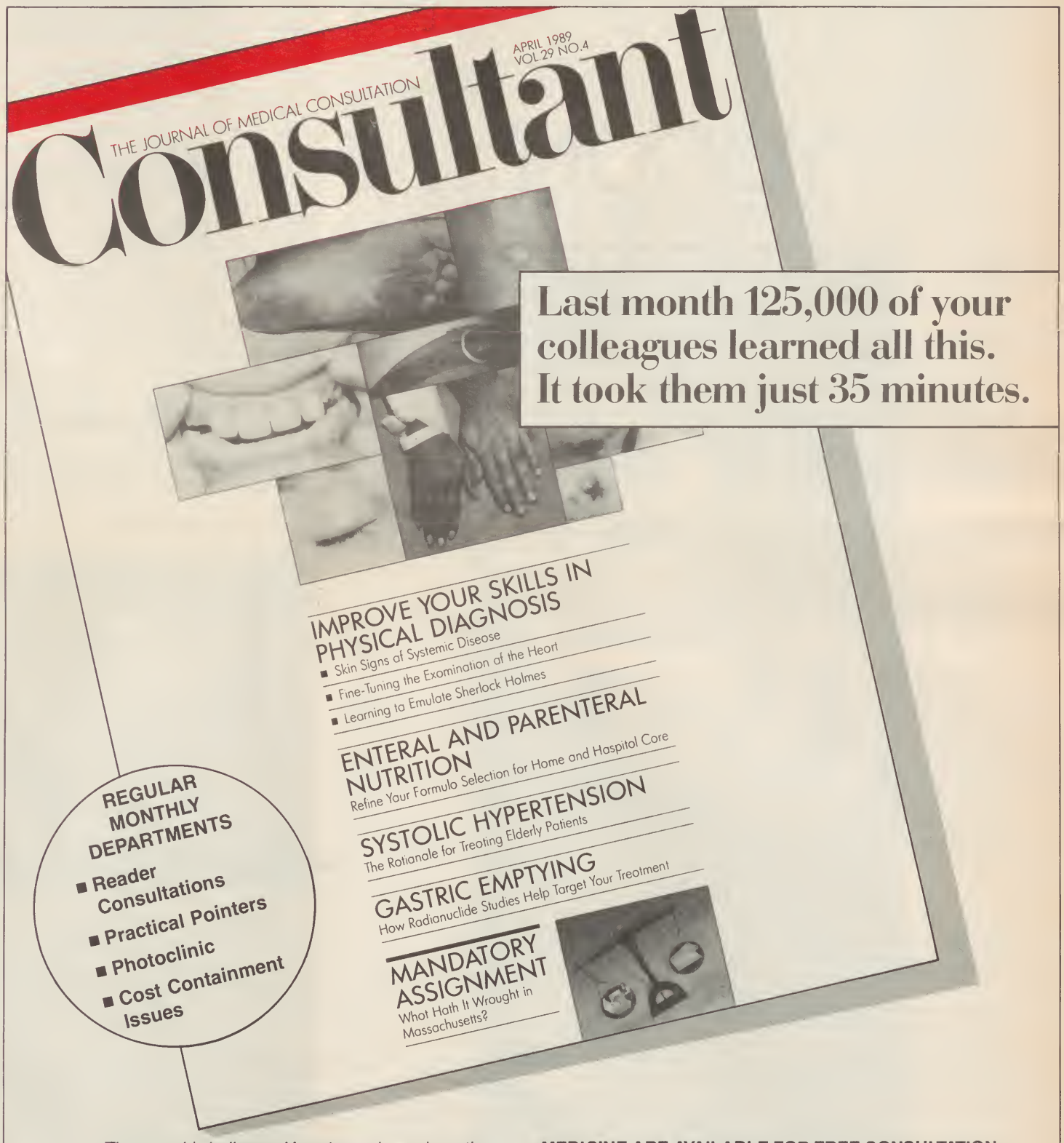
IDPA Director Suter believes it is important to increase access to medical care for people served by the department, and considers ISMS a partner in this effort.

Suter also cited the fight against infant mortality as one of IDPA's major concerns, since a greater percentage of Medicaid recipients have low birth-weight infants. She said this is due to the young age of the mothers, their lack of knowledge about prenatal care, complications in birth and lower-than-average numbers of prenatal medical checkups.

Suter said that significant additional funds have been requested from the legislature for use in reimbursing physicians for obstetrical care. IDPA is also calling for increased reimbursement through the "Healthy Kids" program for office visits which follow the designated preventive care visit. "The medical society provided support for increased reimbursement in the budget," she said. Suter also detailed plans to raise fees paid for office-based services and office surgi-packs.

Suter also noted IDPA's emphasis on quality care for Medicaid recipients. "Peer review is an integral part of the Medicaid program," she said. "Physicians review other physicians, and while several thousand physicians are profiled internally by IDPA staff each year, only a relatively small number are actually reviewed by IDPA's medical quality review committee. This committee then makes recommendations concerning the case

(continued on page 14)



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(continued from page 13)

to the director. Options include closing the case with no further action; suspension; termination, or recommendation for CME. We must maintain the integrity of the program," she said.

Illinois peer review unchanged

Saul Morse, ISMS General Counsel, reassured Illinois physician groups that peer review could safely continue in Illinois under the Health Care Quality Improvement Act because the state laws in effect are similar to that federal law. "Peer review, as long as it is conducted in good faith and with due process, provides immunities," Morse said.

"What does change for Illinois physicians under the new federal law is the credentialing and re-credentialing process," he noted. "The national data bank adds a new piece to the puzzle. According to the federal law, hospitals have to check with the data bank every two years to see if a physician has been disciplined in another jurisdiction," Morse said. According to Morse, final sanctions imposed by Medicare's peer review organization (PRO) are reportable to the data bank.

Eugene P. Johnson, M.D., ISMS president, said the Invitational Forum is part of an ongoing ISMS effort to keep other Illinois physician organizations informed and to create an opportunity for those organizations to share concerns with ISMS. "ISMS speaks for all specialties and physician groups. We must be vigilant in preventing issues from dividing the profession," he said. ▲

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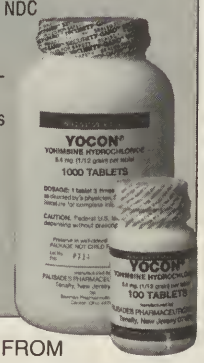
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Experienced family practitioner seeks part-time or full-time work, preferably in HMO, clinic or hospital setting in the Chicago metropolitan area. Reply to Box 2140, c/o *Illinois Medicine,* Twenty North Michigan Ave., Suite 700, Chicago, IL 60602.

Experienced, young G.P. looking for a part-time job in primary care, E.R., or research located between Champaign and Chicago; presently not interested in call or hospital practice. Must be pleasant work environment. David F. Smith, M.D. 100 Center St., Campus, Illinois 60920.

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Entire belongings of medical center for sale: waiting room furniture, desks, examining tables, EKG, spirometry, opthalmoscope, supplies, lamps, lab equipment, Ames chemistry analyser. Call A. Polussa, M.D. 684-3300.

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Dolton, IL area: Practice, equipment and real estate are available. Owner has passed away and a part time physician has been grossing $5,000 per month on a very limited schedule. It is estimated that a full time physician could generate $250,000-$300,000. There are hundreds of patient files. The package is available for $137,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60092.(312) 441-6111.

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Title: Orthopaedic Conference: New Perspectives in Pediatric Orthopedics, An Update. Date: October 5-7, 1989. Location: Landmark Resort in Egg Harbor, Wisconsin. Speakers: Alvin L. Breed, M.D.—Madison, WI; Alvin H. Crawford, M.D.—Cincinnati, OH; Paul Esposito, M.D.—Omaha, NE; John J. Hugus, M.D.—Marshfield, WI; Walter W. Huurman, M.D.—Omaha, NE; F. Stig Jacobsen, M.D.—Marshfield, WI; David C. Mann, M.D.—Madison, WI; H. A. Peterson, M.D.—Rochester, MN; George W. Simons, M.D.—Milwaukee, WI; John G. Thometz, M.D.—Milwaukee, WI; Virginia Garnett-Wintersteen, M.D.—LaCrosse, WI. Further Information: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. (715) 387-5207.

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Illinois Medicine

May 26, 1989

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State employees' health plan slows payments to physicians

THE STATE of Illinois is delaying payments to physicians and other health care providers, some for as long as eight weeks, due to "underfunding" of the Quality Health Care Plan, the group health insurance plan covering many state employees. "It's a temporary cash flow problem," according to Ann Thornsen, public information officer for the Illinois Department of Central Management Services, which coordinates the health plan for 278,000 beneficiaries.

Delayed payments will more directly affect Springfield-area physicians, since the state is the largest regional employer there, with most employees covered by traditional indemnity plans requiring co-payments. A smaller number of Springfield-area patients are covered by HMOs or PPOs. These groups, along with participating hospitals, are guaranteed payment under state contractual obligations to them.

The state shifted to a self-insured health program for its employees July 1, 1986 and assigned Equicor, of Lemont, Illinois, a subsidiary of Equitable Insurance Company, to serve as its claims administrator to process bills. Since then, payments to physicians were usually issued within five or six weeks, but in early April, Equicor was asked by the state to begin delaying payments due to the cash flow problem, Thornsen noted. Some physicians, however, have reported to the Illinois State Medical Society (ISMS) that they are still waiting for payment of February claims.

"Eight weeks is the longest anyone should have to wait," commented Thornsen. Physicians experiencing delays significantly longer than that should report them to the department of group insurance, 217-782-2548, she advised.

Currently, she said, PPOs and unassigned claims are being given payment priority, followed by payment of assigned claims as money becomes available. "We think this cash flow problem is a one-time only thing, and we are processing 1.5 million claims a day for employees and their dependents."

She attributed the problem to underfunding by the Illinois General Assembly for fiscal 1989. "This year's budget was $150 million, less than we needed for the group insurance line item. We have requested $190 million [from the legislature] for fiscal 1990, which begins July 1." That amount will be sufficient to cover the existing 1989 shortfall, she added. But Thornsen refused to specify the exact amount of the shortfall, saying that "it's a changing picture because money is coming in, but just a bit slower than usual."

"We're going to fight like the dickens to keep every penny in the new appropriation," commented Henry Scheff, union benefits analyst for the

(continued on page 17)



Whitney W. Addington, M.D.



Richard M. Krieg, Ph.D.

Daley names new Board of Health; appoints interim commissioner

by Kevin O'Brien

VOWING A "radical restructuring of the city's public health department," Chicago's Mayor Richard M. Daley has appointed a new Chicago Board of Health and an interim commissioner.

"I have assembled some of Chicago's most respected health care experts," Daley said at a May 9 press conference. "Together, they will lead the fight to professionalize our public health care program, and ensure fair and equitable distribution of health

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Ethics in health care: a growing debate on many difficult issues

This is the first of two articles discussing the increasing emphasis on health care ethics and how physicians confront difficult decisions in a changing environment. Part 2 of the series continues in the next issue of Illinois Medicine.

by Janice Rosenberg

The Medical Environment

A periodic observation on issues and trends affecting modern medical practice, and the challenges they present.

AT A GROWING number of hospitals around the country, ethicists are offering physicians guidance in medical decision making. These experts in the field of health care ethics work as consultants, reviewing cases and serving on hospital ethics committees.

The Illinois Hospital Association reports that about one half of the hospitals in the state have established ethics committees. The formation of many of these committees stemmed directly from the 1982 Baby Doe controversy. That case involved questions of life and death for an Indiana baby born with major birth defects.

At the same time, public sentiment had begun to question a physician's right to act unilaterally when his or her decision would determine whether a baby lived or died. To interpret and apply the regulation and to respond to parental demands that other hospital personnel join in the decision making process, hospitals set up ethics committees. Gradually their study of cases expanded

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Physicians surveyed: Withdrawing life support*

Would you favor or oppose withdrawing life support systems, including food and water, from hopelessly ill or irreversibly comatose patients if they or their families request it?

Favor strongly	58%
Favor	20%
Oppose	5%
Oppose strongly	10%
Unsure	7%

Are you certain or uncertain of your legal risks and responsibilities surrounding decisions to withdraw life-sustaining treatment?

Certain	43%
Uncertain	54%
Unsure	4%

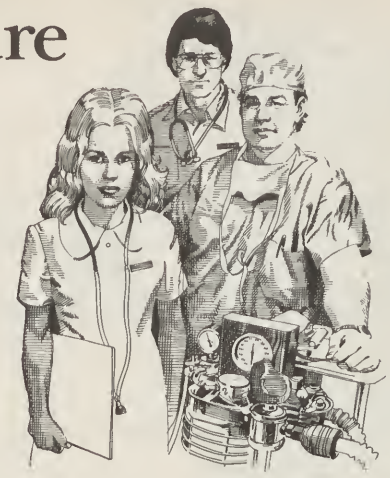
*Approximately 1,000 randomly-selected U.S. physicians were interviewed in 1988; all specialties are represented.
Source of Data: *Physician and Public Attitudes on Health Care Issues*, American Medical Association, 1989.

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Allied health providers seek more stature



WITH BOTH primary care and specialty physicians competing for patients in a growing health care market, patients today have wide latitude in finding the "right" doctor to suit their needs. But groups of allied health practitioners pursuing broader practice privileges and fewer restrictions in the state legislature are looking to further stiffen the competition.

Seeking more authority and status is a wide array of health care personnel: clinical social workers, optometrists, nurse and lay midwives, acupuncturists, medical assistants and registered nurses. Behind the lobbying are motives ranging from gaining direct third party reimbursement for their services, to heightened status, higher pay scales and greater marketing freedom accompanying licensure and independent practice.

In some areas of the state, allied health practitioners are seeking to fill a real health care void. Lack of available obstetrical care in some fourteen rural southern Illinois counties has added impetus to both lay and nurse midwives' case for independent licensure.

Medical doctors, led by their specialty organizations and the Illinois State Medical Society (ISMS), are battling other members of the health care team on many of these licensure bills. Preserving quality patient care is a central issue. But underlying the debate is fear that further stretching of already-shrinking health care insurance dollars to cover allied practitioners will exacerbate access to physician care in Illinois.

While many of these bills are under study in the General Assembly, some have worked their way to the House floor.

Ophthalmologists vs. optometrists

Key among them is legislation allowing optometrists to treat eye diseases by prescribing therapeutic agents that ophthalmologists argue can "affect not only vision, but a person's general health," according to Illinois Association of Ophthalmology (IAO) President Bernard Gawne, M.D. The bill is sponsored by Rep. Zeke Giorgi (D-Rockford).

"In the diagnosis and treatment of disease, it's not always easy to distinguish between simple and complex situations. For example, even drops used in the treatment of glaucoma can put a person into congestive heart failure or precipitate an acute asthma attack," says Dr. Gawne.

Bob Cook, legislative advocate for the Illinois Optometric Association argues, "If a patient has pink eye or something simple that can be treated with a couple of drops, there's very little reason for a person to go to an ophthalmologist. Optometric care can be just as good in certain areas when carefully proscribed in accordance with the law," he says.

Cook adds that "With rising health care insurance, seeing an optometrist would lower the cost of services for people in Illinois."

Optometrists receive clinical training to administer eye examinations for prescribing glasses. Optometrists can administer, but not prescribe, drugs to perform eye examinations, but cannot use therapeutic drugs to treat eye disease. Ophthalmologists are medical school graduates and following medical school pursue four years of residency training. They are trained in the pathology, physiology and pharmacology of the body as a whole, and to diagnose and treat any eye disease with drugs or surgery.

Responding to optometrists' concerns that not enough ophthalmologists are available in rural Illinois, Ronald C. May, M.D., an IAO past president says that no one is more than 45 minutes away from an ophthalmologist.

Optometrists are also pushing for another bill allowing them to advertise their services without identifying what kind of eye doctor they are. Sponsored by Rep. Terry Steczo (D-Oak Forest), the measure is under further study.

"I read an optometrist's advertisement in which he referred to himself as an eye care specialist. This can be very misleading," says IAO lobbyist Zale Glauberman.

ISMS supports the IAO's opposition on both of these bills.

Midwives and acupuncturists

Legislators have also placed on the interim study calendar bills that would license acupuncturists under an independent acupuncture practice board and lay midwives through an independent midwife certification review board. Rep. John Cullerton (D-Chicago) sponsored the acupuncture proposal. The midwives bill, sponsored by Rep. David Phelps (D-Eldorado), would allow for independent lay-midwife practice, prescription of a "formulary of drugs," and third party reimbursement.

ISMS president Eugene P. Johnson, M.D., states that while ISMS does not oppose the proper imposition of standards upon any

(continued on page 14)

Court says legislature is licensure arbiter

Illinois lawmakers are likely to be bombarded with new licensure legislation in the future, as a result of an April Illinois Supreme Court ruling verifying state lawmakers' authority to govern the practice of various medical arts—including who may pursue them and how they go about it.

The high court's April ruling barring naprapaths from gaining a license under Illinois' Medical Practice Act reaffirmed the state legislature's right to establish appropriate qualifications for people wanting to practice medicine, according to Illinois State Medical Society (ISMS) General Counsel Saul Morse. "The court threw the ball back to the legislative arena," said Morse.

The ruling stated that, under the Act, only those graduating from a chiropractic college are eligible for a limited license to practice medicine without using drugs or surgery. Medical and osteopathic physicians are granted unlimited practice authority. Thus, only DCs, MDs and DOs are eligible to pursue naprapathy.

ISMS had filed an amicus brief stating that the legislature appropriately exercised its right to exclude naprapaths, and that naprapathy should not be equated with the practice of medicine by including it under laws governing physician licensure and discipline.

Attorney Timothy Londrigan who represents naprapath Maryann Potts, when she challenged the law after being denied a license by state authorities, argues the legislature's focus is inappropriate. "When the state legislature starts identifying specific colleges by saying, 'You must graduate from this college,' they're showing preference toward a particular school of thought or college," he asserts. "If they wish a particular amount of training, why don't they just state that?"

Illinois' high court disagreed, stating that the legislature can decide both educational credentials and training are needed to gain eligibility for medical licensure. The "classification at issue is based upon the education and training of the practitioners," the court opinion said. "Chiropractors, as a class, have characteristics different from naprapaths .... The General Assembly has determined that only graduates of accredited chiropractic colleges possess the degree of skill and training necessary to practice medicine without the use of drugs or surgery in Illinois."

While the court acknowledged that naprapaths might be just as competent in the art of healing as chiropractors, it asserted that "the legislature is not obligated to permit everyone who might be competent to treat human ailments to do so. A state legislature may deal with matters of health and safety one step at a time, addressing itself to the problem which it sees as being most acute and neglecting the others."

"That means naprapaths—and perhaps other allied health practitioners—are left to do battle in the state legislative arena for licensure privileges," summarizes Morse. A bill sponsored by Rep. Alfred Ronan (D-Chicago) would provide for the licensure and regulation of naprapaths under a naprapathy licensure and disciplinary board. It has been placed on the interim study calendar, which signifies that naprapaths will likely continue the fight during future legislative sessions. ▲

Physician Facts

Prevalence of Drug Use Among High School Seniors, Class of 1986

Drug	% Ever Used	% Used in Last 12 Months	% Used in Last 30 Days	% Use Daily
Marijuana/Hashish	50.9	38.8	23.4	4.0
Inhalants	15.9	6.1	2.5	0.2
Hallucinogens	9.7	6.0	2.5	0.1
LSD	7.2	4.5	1.7	0.0
PCP	4.8	2.4	1.3	0.2
Cocaine	16.9	12.7	6.2	0.4
Heroin	1.1	0.5	0.2	0.0
Other Opiates	9.0	5.2	2.0	0.1
Stimulants	NA	NA	NA	NA
Sedatives	10.4	5.2	2.2	0.1
Barbiturates	8.4	4.2	1.8	0.1
Methaqualone	5.2	2.1	0.8	0.0
Tranquilizers	10.9	5.8	2.1	0.0
Alcohol	91.3	84.5	65.3	4.8
Cigarettes	67.6	NA	29.6	18.7

NA indicates data not available

Source of Data: Illinois Department of Alcohol and Substance Abuse

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On the Legislative Scene



by Caryl Carstens

House and Senate committees have completed action on all bills originating in their own respective chambers. Legislative action now moves to House and Senate floors where bills released from committee undergo further debate. All bills must be acted on in their chamber of origin by May 26. After the Memorial Day weekend, the legislature will begin to consider bills passed in the other chamber.

Medicare . . . S.B. 294, mandating assignment of all Medicare claims, has moved to passage stage (third reading) in the Senate and action was anticipated early the week of May 22, as *Illinois Medicine* went to press. H.B. 402, an identical bill is still awaiting action on the House floor.

Damage award caps . . . Legislation capping non-economic damage awards remains bottled up in House and Senate judiciary committees. The committees are a stronghold for trial attorney advocates. ISMS remains committed to caps, but current opposition is strong and prospects are mixed.

ISMS is also pursuing other tort reforms. Included is legislation requiring an expert's affidavit prior to filing a lawsuit. Since the 1985 tort reform movement launched by ISMS, courts have weakened the requirement that affidavits be filed by physicians practicing in the same specialty. ISMS backs strengthening that requirement. ISMS supports H.B. 247, sponsored by Rep. Lee Preston (D-Chicago), which protects retirement assets from judgments. The medical society is also pursuing legislation, H.B. 1735, sponsored by Rep. Frank Giglio (D-Calumet City), that would provide immunity from liability for physicians who provide treatment to patients at community-based clinics organized to provide free care.

Illinois business-backed tort reform proposals also included capping non-economic damage awards, but they remain trapped in committee.

Written consent . . . A House committee and the full Senate voted down legislation to reinstate written informed consent for HIV testing. Under current law, physicians are permitted to order an HIV test for a patient who has given general consent to treatment provided there is a medical indication for the test. S.B. 166, sponsored by Sen. Dawn Netsch (D-Chicago) progressed to the full Senate for consideration, but was defeated when only 16 of 59 Senators voted for the bill. (30 votes are needed for passage.)

Requiring written informed consent for any experimental procedure is the focus of another bill passed by the House. H.B. 506, sponsored by Rep. Monique Davis (D-Chicago), would require at a minimum, written consent from patients participating in experimental or research programs where an FDA-approved drug is being used for other than an approved purpose. Another version of the legislation, also sponsored by Davis, would have made violation of the written consent mandate a class four felony. However, it did not advance. This issue stemmed from an incident at Cook County Hospital last year in which patients were allegedly administered a drug for investigational purposes without consent.

Legislation requiring radiologists to have a patient's written consent in order to read x-rays was defeated in committee as it has been in prior sessions. ISMS opposed it and its predecessors. The legislation also provided that the referring physician pay the radiologist's fee if written consent is not obtained.

Rural health . . . Legislation to help rural counties where adequate medical care is not available has progressed in the Senate, ready for final action. The package of six bills range from a nursing education pilot grant program to legislation allowing the state to pay up to $5,000 in the malpractice insurance premiums for obstetricians or family practice physicians who include obstetrics cases in their practice. However, physicians receiving such payment must accept all patients seeking treatment. The measures are sponsored by Sen. James Rea (D-Christopher).

Rapidly escalating malpractice insurance premiums have been a ma-

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Correction

The May 12, 1989 *Illinois Medicine* cited an incorrect bill number on mandatory assignment legislation released from the Senate Judiciary Committee. S.B. 294 is the correct number. It is sponsored by state Senator William Marovitz (D-Chicago).

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REPORT FOR *Illinois Physicians*

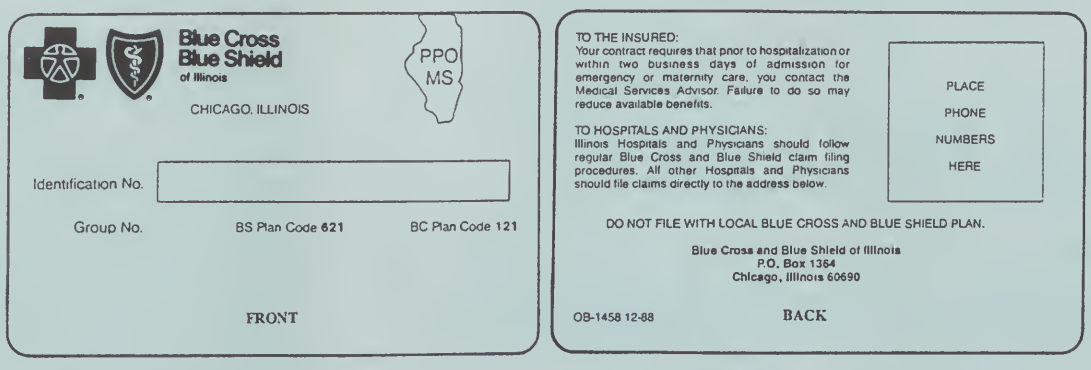
BCBSI INSURANCE CARD GUIDE THE NEW PPO PLUS PROGRAMS

Blue Cross and Blue Shield of Illinois currently offers the most extensive PPO network(s) in the state. As of January 1989, our hospital PPO serves over 700,000 members in Illinois and our physician PPO is operational for two of our largest clients: Illinois Bell Telephone Company and Connell Ltd. Partnership.

The success of our PPO networks has led to the design of our new product, "PPO Plus." This product, combining the strengths of our hospital PPO and physician network, is being marketed in the Chicago metropolitan area to employer groups of more than ten (10) and less than one hundred (100) lives. The PPO Plus product is available in two Comprehensive Major Medical benefit programs with varying deductible, coinsurance, and maximum payment levels. All of these products utilize our Medical Services Advisory (MSA), Blue Cross and Blue Shield's Comprehensive Utilization Management program serving over 1.5 million members.

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Below are samples of the BCBSI card to be issued to subscribers with the new PPO Plus Benefit program. The card is unique; the state of Illinois emblem in the upper right hand corner specifies "PPO MS," denoting both the hospital and the physician PPO benefit program.



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Reimbursement for services rendered by physicians to PPO Plus members will be based on the lower of the Schedule of Maximum Allowances or billed charges. The highlights of the PPO Physician's agreement were featured in the April 28, 1989 issue of the "Blue Cross and Blue Shield Report to Illinois Physicians." A PPO hospital listing and a PPO physician directory will be provided to each PPO physician to assist in the referral process.

If you have any questions regarding the PPO Plus product or the PPO Physician network, please contact Blue Cross and Blue Shield's Hospital and Professional Affairs Department at (312) 938-7073.

(This report is a service to the physicians of Illinois)
5/26/89

Editorials

The allied health providers and "turf battles"

The recent Illinois Supreme Court ruling against licensure for naprapaths upheld the integrity of the Illinois Medical Practice Act, and its built-in safeguards assuring appropriate qualifications for practitioners. The legal battle illustrates the efforts of many allied health providers to use the courts or legislature to obtain independent licensure, as well as increased stature and practice authority.

This is more than a "turf battle" or legal dispute between physicians and other health care professionals. Medical practice by those not qualified to do so could lead to serious illness or death, through undiagnosed, misdiagnosed or improperly managed medical problems. Alternatives and choices are fine in themselves, but when they involve the diagnosis, treatment and prevention of illness, patients need the best talent they can get—provided by physicians with years of intensive medical education and training as backup. Non-M.D. care providers do not have the necessary training to substitute for physicians, and no license or certificate can serve in place of true qualifications. Medical care choices belong in the examining room, not the courtroom. We're pleased the Illinois Supreme Court agreed.

Medical ethics dilemmas

The tragic Linares case demonstrates two factors which have become omnipresent on the American medical scene: fear of litigation on the part of physicians and hospitals, coupled with ponderous bureaucracy. These considerations cause confusion, frustration anger—and often grief—for the public and professionals alike. They are also powerful influences on physicians and other care providers who must struggle daily with difficult ethical dilemmas surrounding life and death.

The growing number of ethics committees in hospitals, and increased attention to medical ethics as an academic field of study can help physicians with guidelines for the most humane, compassionate care for patients. The deeper problem, however, is that what may be the most ethical decision for the patient may be at odds with what is viewed as legal by the courts under our current system. As a result, physicians, patients and their families can be caught in anguishing limbo. Worse, they can be prosecuted as criminals for following the dictates of their hearts and minds.

Whatever your personal views on who is to blame, society must develop firm definitions and consensus for quality of life, death and other basic issues. Illinois' living will and durable power of attorney laws already offer some valuable tools, which physicians should make known to patients. In the meantime, we must be the most aggressive advocates for productive dialogue and clearer guidance on the critical ethical issues of health care ▲

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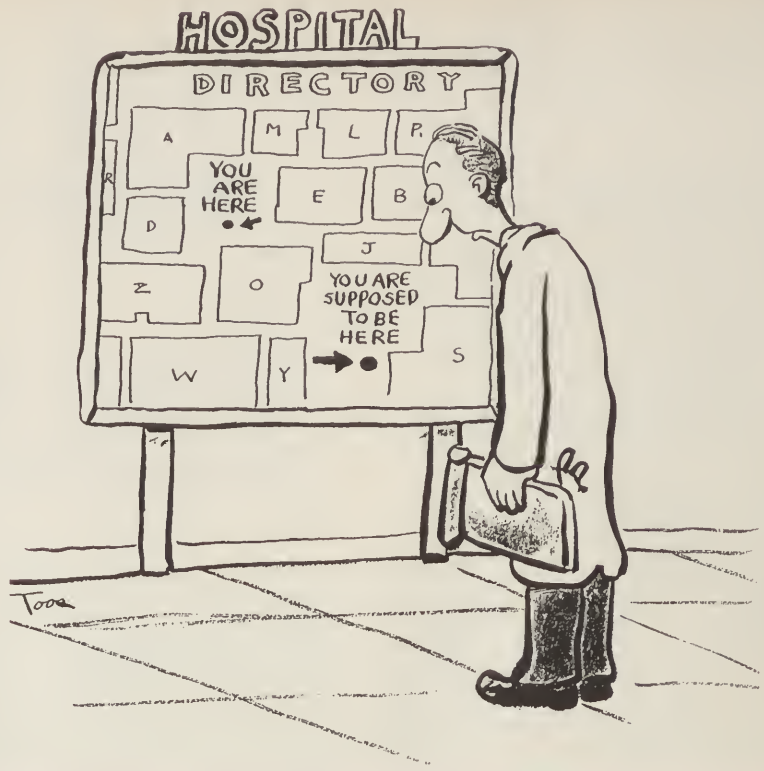
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President's Column

Assignment not Medicare's "fix"



Eugene P. Johnson, M.D.

"Tis the season," as the saying goes, for state legislative remedies which fail to address the real problem. Take mandatory Medicare assignment. In our state, over 68% of Part B Medicare claims are processed on assignment. That means seniors pay only the federally-required Medicare copayment and deductible in the great majority of cases. Forty-one percent of Illinois doctors take assignment all the time. These numbers would seem to indicate that we are sensitive to the varying financial situations of our senior patients.

So what's the problem? It's the perception certain self-styled seniors' organizations are promoting that physicians are "gouging" the elderly. It's the understandable failure of physicians, policymakers and seniors to grasp the complex and convoluted series of Medicare regulations affecting health care. It's the tendency to latch onto simple solutions, rather than tackling the real, underlying morass of Medicare's troubles.

But in politics, perception *is* reality. And that's why mandatory Medicare assignment, born and bred in Massachusetts, has come under consideration in some ten other state legislatures this year.

Luckily, Illinois physicians have the Illinois chapter of the American Association of Retired Persons on our side. Based on AARP's own, independent research, the group's Illinois legislative committee decided mandatory assignment wasn't right for seniors here. They were brave to take a stand that bucks the politically expedient tide of superficial solutions to deep-seated ills.

We physicians know that Medicare needs a fix. But we also know that mandatory assignment isn't the way to fix it. We need to tell that to our patients and our elected representatives in no uncertain terms. You'll find lots of valuable information in the just-previous issue of *Illinois Medicine*.

But we also need to make a greater, long term investment to explain the "squeeze" Medicare is placing on us and our patients—based on policymakers' reluctance to make basic judgments about health care costs and services. Of course it's unpopular to make tough decisions. That's why lawmakers, consumerists and others are trying to force upon our profession the choices of who gets care, how much of it, how intensive the treatment and from where to make up the financial gap in government's reimbursement. Those choices however, are ultimately influenced by government.

We physicians have tried hard to do more with less. We've resisted rationing health care with all our collective and individual might. Such overriding questions are for society to decide. They should not be left to us on an ad hoc, scattered basis. We can and should provide leadership to assist in the decision making process.

Mandatory assignment isn't the answer. Neither are simple cost containment measures. More fundamental questions must be answered. Let's work to make sure that our patients, policy makers and the public at large know it! ▲



Eugene P. Johnson, M.D.
President

Guest Editorial

Physicians cautioned on financial risks in HMO contracts



by Judee Gallagher,
Attorney-At-Law

There may be no such thing as conventional wisdom when it comes to HMOs. Two years ago experts cautioned that consumers and physicians alike might incur less financial risk by dealing with the larger, established HMOs. That kind of logic evaporated recently when Maxicare filed for corporate reorganization under the protection of the Chapter 11 bankruptcy laws.

The action took state regulators by surprise because the subsidiary midwest plans showed a 1988 profit. With the bankruptcy proceeding came court orders which, in effect, prevent physicians from terminating their Maxicare contracts during the reorganization period, assuming payment for services rendered during that period is forthcoming. Another court order prohibits patient billing.

While state legislators are left to mull over the relationship between the bankruptcy action and state regulation of HMOs, the reorganization of one of the largest HMOs pushes the evaluation of the financial risks in HMO contracts to the top of many physicians' agendas. Some of the actions sanctioned by the bankruptcy court are similar to provisions in many HMO contracts. If nothing else, the Maxicare fiasco may encourage contracts which restrict physicians' risk. Physicians should consult an attorney before signing any contract.

At a time when over half of Illinois HMOs are operating at a loss, nothing looms larger in considering financial exposure than the prohibition on patient billing for covered services—a standard provision in HMO contracts. Even physician groups in the best bargaining position have been unable to eliminate the ban, partly because employers insist on it to protect their employees.

Look at key contract provisions

Unlikely as it is that this will change soon, key contract provisions should be negotiated with the prohibition in mind. Contracts should specifically require regular financial reports, including independently audited yearly financial reports, including independently audited yearly financial statements. If they are not forthcoming, contract termination should be an option with only minimum notice required. Since many HMOs operate at a loss, physicians will have to compare the loss with the HMO's net worth to evaluate financial risk.

Physicians should also be aware that the patient billing ban for covered services is less restrictive in some contracts than others. For example, some do specifically allow for patient billing when the payment denial for a covered service is due to patient behavior. Others permit such billing when the patient agrees in advance to pay for a service which the HMO refused to certify as "medically necessary."

Physicians should be *very cautious* about accepting financial liability for services they do not directly provide. This can take the form of primary care doctors required to pay for laboratory services directly and reimbursed by the HMO, or physicians who accept liability for deficits in hospital and other risk pools. Avoid open-ended withhold arrangements and obtain information on the track record of withhold pay backs before participation. Deficits can easily result from inadequate HMO funding, not overutilization. Further, utilization is a function of how and to whom the plan is marketed, as well as physician behavior. Not only should status reports on risk sharing arrangements be required, but the reports must include meaningful information. Failure to promptly provide them should trigger a physician's termination options with minimum notice.

Defining "minimum notice" for maximum protection

What is minimum notice? State HMO regulations require physicians to give at least 30 days notice of contract termination. Some HMOs, mindful that their leverage is enhanced by longer notice provisions, require six times the regulatory minimum. Further, some HMOs only allow contract termination on the contract renewal date. One Chicago area HMO, which has consistently paid capitation fees late, changed its contracts to make termination more difficult for physicians. Leery about the HMO's financial position, one medical group was able to terminate the relationship without undue delay, because the group was still operating under an older version of the contract.

Financial risk can follow the physician after contract termination too. Some contracts require the physician to continue to provide care until the expiration of the group employer contracts. Most also require physicians to continue to provide care to hospitalized patients or those members receiving treatment at the date of contract termination. The problem, of course, is not with continuing this type of care. But compensation by capitation when all the HMO members left on your roster are ill is inappropriate. And that is exactly what some contracts require. Other contracts pay physicians for such care according to a negotiated fee schedule.

As in all negotiated matters the financial condition of your contractor is extremely important. Minimum notice requirements will not produce payment from a bankrupt contractor, but may contribute to maximum protection from your contractor's financial instability. ▲

Ms. Gallagher is a private practice attorney representing physicians in health care legal matters. She was counsel to the former ISMS Office of Contractual Services.

Letters to the Editor

Rural representation on Medical Disciplinary Board

I read with interest the lead article, "Dissecting discipline" in the March 31 issue of *Illinois Medicine*. It was most interesting to me, and not a little frustrating, that the members of the Medical Disciplinary Board were all from strictly urban areas. Now, I grant you that Decatur may sound very rural to someone who lives in Chicago. However, Decatur still has over 100,000 people living in it and so qualifies as nothing if not urban. Since there are a large number of rural practitioners in the state, I can only come to the conclusion that it is generally perceived that rural practitioners are not competent to stand in judgment over their peers.

It has long been evident to me that almost all judgment is handed down from the urban citadels on into the hinterlands in a very strict hierarchical fashion. That is why I find the sudden concern with the status of "rural medicine" to be laughable and hypocritical. When I was a medical student, we were distinctly told it was a waste of intellect and talent to merely practice medicine in an isolated area and to try to be of service to one's fellow human beings.

Only research which presumably can only be accomplished in an urban setting, was of any value to those who taught us. These and other types of myths persist remarkably well in spite of physicians generally being self-congratulatory about their ability to think freely and scientifically. For once I would like to see more than lip service paid to the rural practitioner. Thus far we are valued only for our referrals, not for our opinions on anything, be it scientific, political, social, or anything else.

For starters, it would be most gratifying to see at least one rural practitioner on the Medical Disciplinary Board. I can't imagine that any of the physicians on the present board have any current practical experience when it comes to practicing medicine 100 miles away from the nearest CT scanner or 50 miles away from the nearest obstetrician. They may know in theory, but probably not in fact. I would find it most pleasant to be corrected if I am wrong.

William Schuler, M.D.
Mendota

Osteopathic physicians

I am writing in response to the repeated insults that are inflicted to my profession by *Illinois Medicine,* the newspaper produced by the Illinois State Medical Society (ISMS). I have been a member of ISMS for four years, and during that time I have seen numerous articles referring or inferring that osteopaths are not medical physicians or something less than M.D. physicians.

The latest inference that I saw was in the March 31 issue, front page article, entitled "Dissecting discipline." The second paragraph begins "yet, the five *physicians,* one osteopath, one chiropractor . . .", this can and was misconstrued that osteopaths are not true physicians.

There are numerous subtle, and sometimes not so subtle paragraphs included in your issues over the past years. I am writing to make you aware that the scope of your readers includes many individuals who are uninformed as to the aspects of osteopathic medicine. Those readers who are ignorant of the differences between the professions can easily get the wrong impression when they read a well-known journal such as yours.

Responsible journalism must include factual information written without bias. Osteopaths are indeed a separate discipline than allopaths, but both attend medical school, take similar medical boards, and are considered fully licensed medical physicians.

It is for this reason I hope future articles are written from a more careful perspective. If differences are to be made between the two disciplines let it be differentiated as allopathic vs. osteopathic. If medical training is to be discussed please do not use the verbiage medical vs. osteopathic. If an event that includes many of the D.O.s and osteopathic students occurs, an article should be included within your pages. After all there are numerous osteopaths and future D.O.s within ISMS, and your organization is represented as the Illinois State Medical Society.

I look forward to future articles and ISMS journals and, in light of my letter, a better understanding and more professional use of the English language.

Andrew Solkovits
Chicago College of
Osteopathic Medicine
Forest Park

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting complaint—A 24-year-old woman in the early weeks of her first pregnancy developed a rash and was mildly ill. She had confirmed the pregnancy with an over-the-counter testing kit and had made an appointment, but had not yet seen a physician.

The subsequent diagnosis—When the patient saw the physician, she told him she had concluded that she was pregnant, and he diagnosed rubella. He immediately ordered a pregnancy test, and from his own examination determined that she was about nine weeks into her pregnancy. The woman could not recall whether she had been immunized against rubella, so the physician ordered a hemagglutination-inhibiting antibody test. He ordered a second HI test two weeks later and confirmed evidence of an acute rubella infection.

At that point, the physician met with the patient and fully explained the general risk to the fetus posed by her rubella infection and described possible birth defects that might occur. All options were presented to her, among them, a therapeutic abortion. The patient took the news calmly, discussed the situation with her husband, and both consented to terminate the pregnancy.

The physician performed the abortion without complications, although the woman did telephone him twice after the procedure complaining of chills and heavy bleeding. He responded to both calls and, after the second call, advised the patient to come to his office. That was the last contact the physician had with the patient.

The resulting claim—The patient and her husband filed a claim alleging failure to treat her post-abortion problems and suggesting that the physician had forced them into the abortion.

The outcome of the claim—The claim was dismissed without payment. The physician had adhered to the basic standard of care for diagnosing rubella as outlined by the American College of Obstetrics and Gynecology. He had fully explained the possible risks to the unborn fetus posed by the rubella infection and he had outlined all the options possible. He also had obtained proper consent and documented this consent on the appropriate forms in his office. He had responded to the woman's two evening calls complaining of bleeding and chills but said she had failed to cooperate with him in postop care. She never came to his office the day after the second call as he had advised her to do.

Why this patient really sued—There were no problems in defending this case and it was dismissed without payment very quickly. Information obtained by attorneys for both sides, however, revealed why the patient and her husband filed a claim. According to the couple, their real complaint was not so much about the quality of the medical care that the physician had provided as it was about his personal demeanor. The woman said the doctor had been cruel and cold and in effect had implied that they had little choice about whether or not to have the abortion.

The points this case makes—Many professional liability actions arise out of perceptions by patients and their families that physicians have been uncaring, callous and brusque in their dealings with them. "If a physician has not sat down with the patient and talked to him honestly about his problems, has offended him by ignoring his legitimate complaints, or has simply behaved in a way which indicates to the patient that the physician 'couldn't care less' whether he recovers or not, that patient is quite likely to be completely uninhibited about consulting a lawyer and filing a suit if anything less than a perfect result is achieved," wrote Angela Roddey Holder, counsel for medicolegal affairs, Yale New Haven Hospital, in her text, *Medical Malpractice Law.*

One large midwestern hospital with an active cardiovascular surgical department suddenly found itself faced with half a dozen potential claims arising out of cardiac bypasses. The preop procedures were excellent—every step of the scheduled surgical procedure was carefully explained, personal visits to patients were made by the individuals on the surgical team, and the whole process exuded caring and concern about the individual's problems. The postop process was not so carefully thought out. Patients who developed complications, not uncommon in cardiovascular procedures, explained that while they were given proper care, the personal rapport that had characterized their presurgical period was missing. They were often referred to consultants and never saw the surgeon again. Many felt slighted, ignored by the very individuals who had appeared concerned about them before their surgery. The surgical team was made aware of this perception, new procedures were instituted to remedy this lack of personal follow-up, and the claims stopped.

Every physician is different and each has his/her own personality and emotional make-up. Even so, consultants remind physicians of the importance of building and sustaining a continuing good relationship with patients. A good physician-patient relationship is synergistic—fostering the healing process. Some points that bear repeating:

- —Listen to what patients have to say;
- —Be kind and compassionate;
- —Be courteous;
- —Be considerate;
- —Don't make patients feel rushed;
- —Explain things to patients in terms each can understand;
- —Respond to patients' calls for advice, for assurance and care; and
- —Take each person's complaints seriously; they are serious to each patient.

When patients are satisfied with the way that their physicians have dealt with them as individuals, they are less likely to sue if something does go wrong. What one woman had to say gives additional support to this statement. "I was very ill and scared, but the doctor answered my questions and comforted me. She prepared me for what would happen, and despite several complications, I wouldn't have dreamed of suing her." ▲

Physicians' Benefits Trust improves insurance program

by Diane Valletta

THE MERGER OF the insurance benefit programs of the Illinois State Medical Society (ISMS) and Chicago Medical Society (CMS) to create the Physicians' Benefits Trust (PBT) has resulted in significant advantages for those members who participate, according to Arthur R. Peterson, M.D., chairman of the trust.

The Physicians' Benefits Trust currently offers a variety of health, life and casualty plans for physicians, their employees and dependents. (See sidebar on page seven.) And under a special new program, term life insurance coverage in the amount of $10,000 is offered free to all resident physician members.

The opportunity to purchase insurance coverage on a group basis is a valuable benefit of professional association membership. For many years, ISMS and CMS sponsored essentially the same types of insurance plans to their respective memberships. Both offered life, health, disability and other plans, and in some instances were soliciting the same physicians.

How the Trust began

In 1987, leaders of both societies began discussing the possibility of combining the programs. Investigation revealed that a merger would benefit physician members as well as the two organizations. Eliminating the costs of conducting duplicate insurance administrative activities and of competing with one another for participants meant that each organization could operate on a more cost-efficient basis and work together for the benefit of their members.

More importantly, a merger would create a larger insurance group, which tends to favor the physicians who participate in the group for two reasons: (1) the larger the group, the greater its leverage when program features are negotiated with insurance companies; (2) rate increases are determined on the basis of the claims experience of the group. This is because insurance is premised on many people sharing in the cost of paying the claims of the few who have them in any given year. Based on the law of large numbers, the greater the number of participants in a group, the more stable its claims experience from year to year.

The newly created Physicians' Benefits Trust enlisted broker/administrator R. T. Nelson & Associates to handle the insurance programs of both medical societies and combine them into one. The Nelson team carefully analyzed both programs, then conducted an extensive marketing study, interviewing society members throughout the state to determine what physicians wanted most from their insurance programs.

PBT Physicians' Benefits Trust
sponsored by Chicago Medical Society & Illinois State Medical Society
Administered by R. T. Nelson & Associates, Ltd.

Then Nelson amalgamated the two programs, keeping the best of both and adding benefits according to membership preferences. "Members requested that there be no pre-certification requirement, second surgical opinion or pre-admission testing, and that rating differentials based on regional location be maintained," according to Teresa Neufeld, R. T. Nelson & Associates. The result is a package of custom-tailored insurance plans that are specifically designed to fit the unique situation of physicians, their employees and dependents.

An all-physician governing board

A key goal of the trust was to make sure it remained responsive to, and an advocate for, the needs of the physicians it served. This goal was met by establishing a board of trustees composed entirely of physician volunteers who are also medical society leaders. Representing ISMS on the current board are Raymond A. Dieter, Jr. M.D., of Glen Ellyn and Alfred J. Kiessel, M.D., of Decatur. Representing CMS are Joan E. Cummings, M.D.; Arvind K. Goyal, M.D.; Alan H. Hollett, M.D.; Arthur R. Peterson, M.D.; Earl N. Solon, M.D.; and M. LeRoy Sprang, M.D.

The board meets quarterly to review the programs, monitor claims experience and evaluate the validity of rate adjustments. According to Dr. Peterson, they are always looking for new programs or ways to make the existing ones more competitive. As an example, the full psychiatric benefits now included in the PBT major medical plan are unavailable in most other plans on the open market. "After considerable discussion, a proposal to self-fund the major medical programs offered by the trust was approved at the board's April meeting. The new self-funded plan

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became effective May 1, 1989, and is designed to give the trust more latitude in its major medical offerings," according to Dick Bennett, the trust's managing director and secretary.

Growing participation

Since PBT's creation, medical society-sponsored insurance plans have become more popular among physician members, said Bennett. Participation has almost doubled since 1985, and members throughout the state are represented, he noted.

Physicians currently enrolled in the program report satisfaction about program benefits, cost competitiveness, and the promptness of claims payments. "I'm very satisfied with the program," said Richard Blankshain, M.D., of Oak Park. "I find that claims are settled promptly and fairly, and the new program features a broad range of benefits. I'd advise others to consider the program."

Richard Geline, M.D., of Skokie, agrees that he received prompt, helpful service on two recent claims he filed, with no questioning or challenges such as he had experienced with other companies in the past.

"We encourage all members to frequently review their current insurance program," Dr. Peterson suggests. "Always be aware of what coverage you do and don't have. And periodically compare your program to the trust's offerings. As participation grows, so will the superiority of our rate structure and benefits."

For more information on any of the plans offered by the Physicians' Benefits Trust, call the plan administrators at 312-559-9130 or 1-800-621-0748. ▲

Physicians' Benefits Trust custom insurance plans offer flexibility

The Physicians' Benefits Trust offers a full range of insurance plans designed to match the professional and personal needs of physicians, their employees and dependents.

Office benefits program
A comprehensive health and disability package for group practices with five or more employees.

Major medical
Hospital, medical and surgical benefits. For physicians, their employees and dependents.

Excess major medical
Catastrophic coverage for physicians and dependents.

Long term disability income
Provides income replacement in the event of partial or total disability.

Medicare supplement
Covers physicians and spouses age 65 and older for health care expenses not paid by Medicare.

Term life insurance
Available for physicians, dependents and employees. Special offer of free term life insurance for residents.

Office overhead expense
Covers operating expenses of the practice in the event of physician's disability.

Accidental death and dismemberment
Covers physicians for fatal or dismembering accidents.

Professional liability
Professional liability (malpractice) program available through the Illinois State Medical Inter-Insurance Exchange.

Dental plan
Available for physicians, employees and dependents.

Personal umbrella liability
Protects personal assets in the event of liability judgment against a physician. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *What liability limits are best for me?*

A: The Illinois State Medical Inter-Insurance Exchange (ISMIE) offers a variety of limits from a minimum $250,000 per claim/$750,000 aggregate per year to a maximum $2 million per claim/$4 million aggregate per year. The choice of limits is left up to the individual physician. The limits required for adequate protection and comfort level vary by practice specialty, location and setting. Hospital requirements for medical staff privileges usually establish a "minimum" liability limit. All employees within a group practice should carry equal limits. Keep in mind that if the amount of insurance chosen does not cover all of the claims reported during the year, personal assets can be at risk. ▲



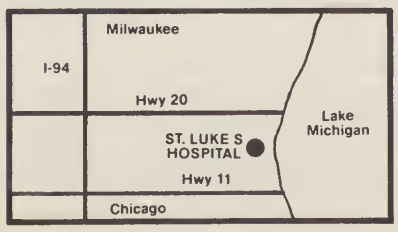
The difference between ordinary and extraordinary... is how well you know your lessons

...And the extraordinary gastroenterologists at St. Luke's Hospital's Digestive Disease Center know their lessons well. In fact, from them, hundreds of other physicians and nurses from around the world have learned the specialized techniques and procedures that have become the standards of today. Highly specialized procedures for the pancreatic and biliary tract have been developed and perfected such as ERCP, Sphincter of Oddi Manometry, Spincterotomy, Biliary Tract Dilatation, Biliary Tract Stent Placement, Biliary Tract Stone Extraction, Pancreatic Stenting, Nasobiliary Cholangiogram and Brush Cytology.

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(continued from page 1)

from the care of newborns into other hospital services.

Training ethics experts

Physicians on newly-created ethics committees found they needed help in examining the alternatives of complex cases. This led to a search for specialists in health care ethics.

Just five years ago hospitals had difficulty locating such experts. University philosophy departments served as an initial source. Demand for ethicists has led some universities to create new programs in their philosophy departments. Graduates are known as ethicists.

At Loyola's lake shore campus in Chicago, doctoral candidates in philosophy can specialize in ethics and sub-specialize in health care ethics. "Some of the Ph.D. candidates intend to teach in universities," says David Ozar, Ph.D., director of the graduate program in health care ethics at Loyola. "Others have as a primary goal to become ethicists or ethics consultants at major medical centers or large community hospitals."

The ethicist as teacher and consultant

Ozar himself serves as ethicist for Evanston Hospital. In his primary role of educating the house staff, he gives monthly ethics rounds and acts as co-director of the hospital's Great Books course in medical ethics, a once-a-month discussion group for house staff and attending physicians.

Physicians can and should handle moral dilemmas in a way analogous to how they handle infectious disease or cardiology problems.

Ozar is also available as a consultant on specific cases. He is skilled in enabling people to understand the practical implications and consequences of holding particular moral views. "Most people," he says, "have not clearly thought through their moral or ethical views about matters. Most people don't even try to articulate these things except in a crisis of some sort."

Showing people the way through the thicket of a moral dilemma is Ozar's job. Unlike medical consultants, he does not provide answers. "I help people articulate their views," he emphasizes. He also brings to the discussions his knowledge of the literature on ethics. "I see myself as facilitating people's thinking processes."

An ethics committee at work

Eugenie Gatens-Robinson, Ph.D., an assistant professor of philosophy at Southern Illinois University, Carbondale, is an ethicist and a member of the ethics committee at Memorial Hospital in Carbondale. "Our mission is advisory," she says. "The committee is brought into action at the request of a physician, nurse, or other health care worker who finds a case problematic and wants it discussed. We bring the people involved together to give us their points of view."

Today's medical solutions are so complex, no single individual feels either required to or even capable of making decisions in isolation. . . .

Once the committee has heard from those involved in a particular case, members discuss the situation, form a motion, and take a vote. William Hamilton, M.D., who heads the committee, then sends a letter describing its opinion to the physician in charge of the case.

"This is helpful to the physician and the family," says Gatens-Robinson, "when he or she and the family are having a problem deciding something about the patient—for example, whether they should be taken off a respirator or whether further intrusive procedures should be done when it is not clear that they will help."

Dr. Hamilton sees the inclusion of an ethicist on the committee as adding another dimension to their decision making process. "It keeps us from being locked in on just legal or medical issues. We rely on the ethicist as another source of expert information." And, he notes, the ethicist's knowledge of how similar cases have been decided in court prevents the committee from making recommendations that are not appropriate.

Ethics consultations vs. standing committees

Mark Siegler, M.D., directs the training of physician ethicists at the University of Chicago Pritzker School of Medicine's Center for Clinical Medical Ethics. Dr. Siegler also devised the ethics consultation service for the University hospitals. He feels strongly that a consultation service works better than a standing committee because the concept of calling in an expert in a particular field is familiar to all physicians.

"We respond only to consultation requests. We don't get involved in staff education or policies," says Christine Cassel, M.D., chief of general internal medicine at the University of Chicago Hospitals, and a physician ethicist. "Physicians and staff, when faced with a difficult ethical dilemma, can ask the consultation service to see a patient. We have a once a week meeting where we discuss the issues and the cases. Obviously, if something is more urgent, we are on the spot to deal with it."

"Today's medical situations are so complex," says Dr. Cassel, "No single individual feels either required to or even capable of making decisions in isolation, particularly since modern medicine is so public. Every decision has to be documented, justified and shared with a number of providers as well as insurers."

Discovering patient choices, and the best medical solution

Following his residency in internal medicine, John La Puma, M.D., took the two year fellowship in ethics offered by the University of Chicago.

In August, 1987, he joined the staff of Lutheran General Hospital in Park Ridge. Dr. La Puma does ethics consultations throughout the hospital. After seeing and examining a patient, he talks to family members, nurses, other medical consultants, social workers, and the pastor or rabbi involved. Then he sits down with the attending physician and the resident, and tries to help identify and analyze the ethical problems in the case. When he has pointed out the pros and cons of various approaches to these problems, he often suggests a resolution.

"Physicians can and should handle moral dilemmas in a way analogous to how they handle infectious disease or cardiology problems," says Dr. La Puma. "They need to understand some of the basic principles and processes of clinical ethics, know how to discover patient values and choices, and figure out how to work with them to create the best medical solution."

Problem solving is a major role

Henry Ruder, M.D., chairman of the medical ethics committee of Northwestern Memorial Hospital, emphasizes this necessity for arriving at medical solutions when ethical issues are presented. "You need to understand the medical problem that is being discussed," he says. "The purpose of our committee is to solve problems, to get things done properly, and to help the patient, physician, and family."

In order to do this, Dr. Ruder's committee is composed of a broad range of people including both a physician with training in ethics and a lay ethicist. Father James Bresnahan, co-director of Northwestern Medical School's ethics and human values in medicine program, serves as lay ethicist for the committee. He has a long standing interest in health care ethics and participates actively on every team assembled for a consultation.

When an attending physician calls for an ethics consultation, the core committee is assembled along with guests from the hospital who are experts in the particular field. "Once we've seen the patient and heard the issues we discuss theories and apply them to the case," says Dr. Ruder. Again he stresses the need for solutions. "If you don't have the medical expertise you can have a wonderful discussion of philosophy, but it's not going to help the attending physicians. You don't have the option of running a twelve week course on what to do. Something has to be done, a decision has to be made."

Today, physicians all over Illinois are turning to ethicists and physician ethicists for help in making those decisions. ▲

Linares case highlights ethical dilemma

On August 8, 1988, seven-month-old Samuel Linares became a patient in the pediatric intensive care unit at Rush Presbyterian St. Luke's Hospital on Chicago's west side. That day Sammy, at a birthday party, had aspirated an uninflated balloon.

The balloon lodged in his posterior pharynx, blocking the area around the epiglottis and closing off both the esophagus and the trachea. Sammy's father, Rudy Linares, tried but could not remove the balloon. Emergency personnel removed it with a laryngoscope. The medical facts of Sammy's case were clear. Although he had brain stem reflexes and cortical activity on his EEG, his doctors considered him to be in a permanently unconscious, chronically vegetative state.

"The parents requested that we do no more for their child," says Gilbert Goldman, M.D., director of the pediatric intensive care unit at Rush, "And this seemed reasonable to us at the hospital from an ethical point of view."

According to Dr. Goldman, they agreed to do not resuscitate orders. No additional levels of care or new therapies were to be added. Complications were not to be treated. The doctors told the Linares family that a court order permitting the life-support equipment to be disconnected would be supported by the hospital.

Four months later, in December, 1988, Dr. Goldman says the parents had shown no interest in following that course of action. Sammy's condition remained unchanged. His father, Rudy Linares, made an unsuccessful attempt to disconnect the life-support equipment. Sammy did not suffer any complications as a result of his father's action. The doctors once again told the parents that the hospital would cooperate with any attempt to obtain a court order permitting disconnection of the life-support equipment.

On Wednesday, April 26, at one a.m., this time with a gun in his hand, Rudy Linares again disconnected the equipment. The child died and the father was arrested by Chicago police. Murder charges against him were dropped May 18.

"In cases like Sammy's where the medical personnel and the legal guardians are in agreement on what should be done," says Dr. Goldman, "We need a clarification of the legal standing of the child. The major dilemma for us is that we have no judicial precedents or legal statutes in Illinois which allow us to withdraw life-support therapy when we know it will lead immediately to the death of the child. If anything positive was going to come out of this controversy, it would be to spur the legislature or the courts to develop clearer guidelines for us."

Richard Epstein, senior fellow at the center for clinical medical ethics at the University of Chicago, does not agree. "Until now cases like this have been decided between the parents and the hospital. Customary practice is often times better than legislation," he said. "I almost hope that legislation will not be passed as a result of this."

Ethicist Kenneth Vaux, Ph.D., professor of medical ethics at the University of Illinois-Chicago, also thinks that cases like this should be decided among parents and medical teams. While he does not want to see the Linares case become a precedent, he states that, "When a human being is irretrievably brain dead it's wrong to keep him alive, a punishment to keep forcing breathing into lungs that no longer function on their own." ▲

What's good for the goose . . . ?

COULD it be? Is what's good for the doctors also good for the lawyers? It seems that way, but one can't be certain because no one will admit it's his or her idea.

Amidst the deluge of bills introduced in the General Assembly this session was one to revise the statute of limitations for filing malpractice suits against attorneys. If this sounds familiar, it's because similar ISMS-backed legislation for physicians won approval in 1987.

H.B. 554 would have permitted a legal malpractice claim to be filed within two years of discovering the alleged malpractice, but no more than four years thereafter. However, in the case of minors, the bill would have reduced the time period to five years from the date of discovery, but in no event after the claimant's twenty-second birthday.

Current law says that the statute of limitations clock does not start running until age 18, thereby allowing suits to be filed up to age 22 no matter when the incident occurred. The lawyer's bill generally tracks the doctor's law, except that legal malpractice claimants would face an even tighter deadline: plaintiffs have eight years to file a medical malpractice claim instead of the proposed five for legal malpractice.

"Attorneys wanted the same benefit the doctors have," said Rep. E. J. "Zeke" Giorgi (D-Rockford). Giorgi, who was assigned the task of shepherding the bill through the legislative maze, wouldn't say who asked for the legislation and denied that any legal professional association was behind it. In any case, the bill died in committee.

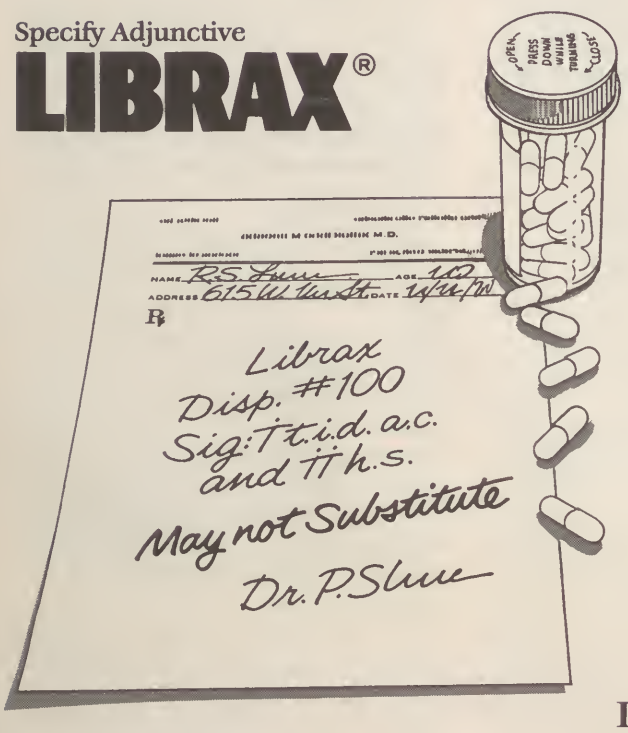
The Illinois State Bar Association, which started its own captive insurance company in 1988, wants a statute of limitations bill, but not this one. "We do not support this particular bill because it's too restrictive," said Marylou Lowder Kent, director of legislative affairs.

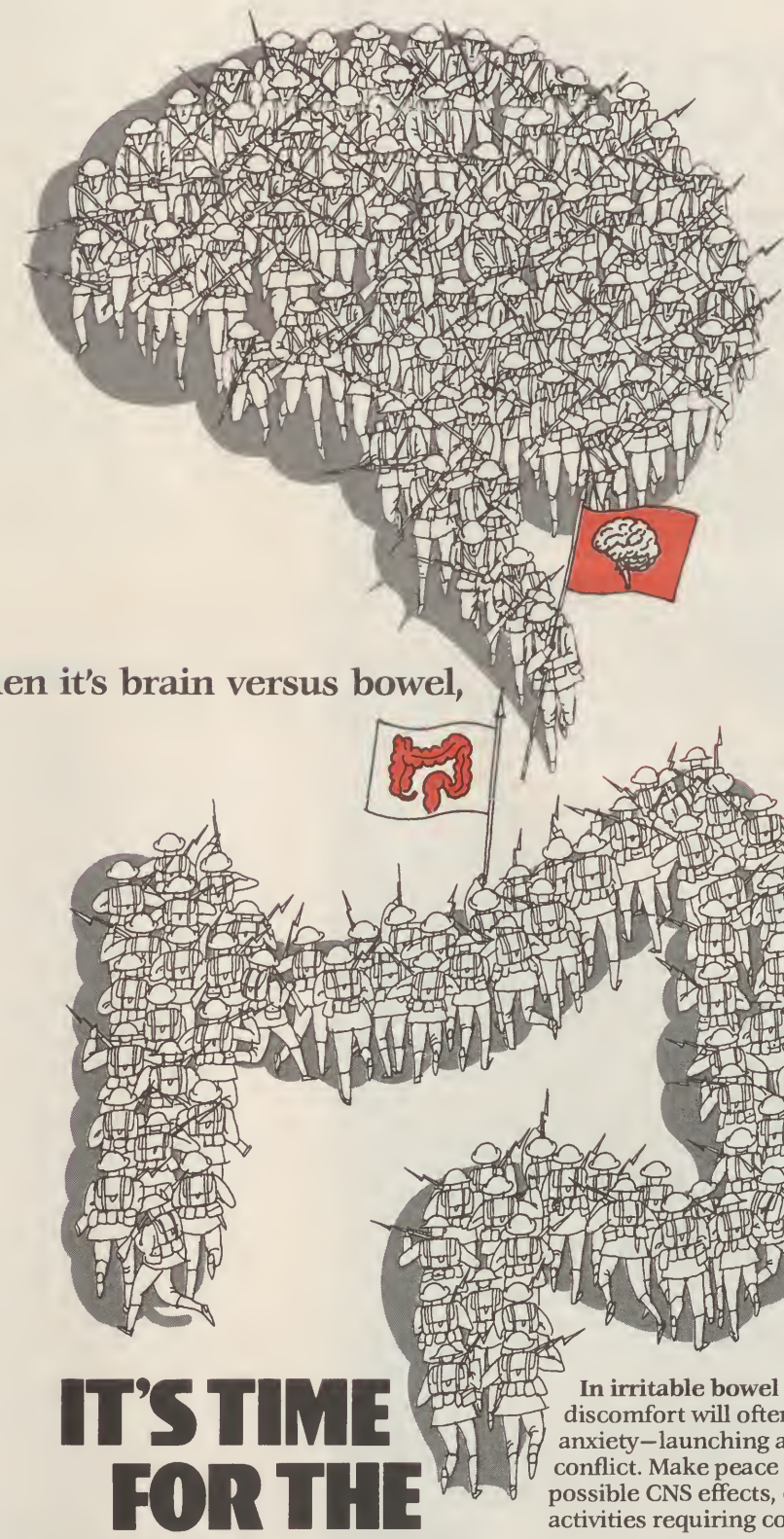
Kent said they favor a 10-year "repose" period instead of the proposed four years, and they also favor the existing law for minors. Kent said that the association is working on its own proposal.

The Illinois Trial Lawyers Association, which vigorously opposed the 1987 legislation granting physicians relief, also opposed the attorney's bill. "We oppose it for the same reason that we opposed doctors having a shortened statute of limitations, it hurts people," said executive director James J. Dudley.

A spokesman for the Illinois Public Action Council (IPAC), which also fought the ISMS-backed legislation two years ago, said that they would not be taking a position on the current legislation. ▲

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John J. Ring, M.D. seeks reelection to AMA board

SOMEHOW, John Ring, M.D., Mundelein, manages to actively practice medicine. "I'm lucky enough to have 'hard core patients' who like me and understand when I'm gone. And good friends and colleagues in Lake County who help cover for me," he explains with a smile.

The reason: Dr. Ring currently chairs the American Medical Association's Board of Trustees, and in that capacity has travelled the country—and various points beyond—to press medicine's case before health policy makers on behalf of the organization's 250,000 plus members.

Dr. Ring is again running for reelection to the AMA's board, having already been elected twice to three-year terms. The upcoming June election at the AMA's annual house of delegates meeting marks his third campaign for trustee. "It's a tribute to John's knowledge of issues affecting physicians and his leadership that the AMA board has elected him its chairman," says Eugene Johnson, M.D., ISMS president.

Dr. Ring sees his AMA trustee job as doing "everything in my power to hold us together." "Us" means organized medicine, which according to Dr. Ring faces more potentially divisive issues than ever before. "Hospitals trying to control physicians . . . federal and state governments attempting to reduce already inadequate reimbursement while demanding quality care . . . third party payors trying to dictate how physicians practice . . . strong differences among physicians on a new method of reimbursement for relative values . . . some groups of doctors looking at just what is good for them . . . are but a few of the issues trying to tear us apart."

Medicine's biggest dilemma today boils down to one central theme, he says. "It's third party interference in the practice of medicine, and their attempts to use doctors as rationing agents for health care when rationing is really being done by the payors."

Despite Dr. Ring's insistence that he's an "ordinary physician," many doctors would be hard pressed to keep up with his pace. But he thinks it's important that organized medicine's leadership stay in practice "so that we're exposed to the problems on a grass roots level."

In fact, he credits his success in organized medicine to strong roots in the Lake County and Illinois medical communities. "It's not one guy out there conquering the world—it's really teamwork that counts. That makes my decision to run for reelection an easy one. I've got lots of help," he adds.

George Wilkins, M.D., heads the Illinois delegation to the AMA. "The delegation is very honored to have Dr. Ring as our AMA standard bearer, and we're especially proud he's serving as AMA chairman," he comments. "We want him to return for another three year term on the board." Dr. Wilkins agrees that Dr. Ring's success comes from paying attention to the grass roots. "He's never forgotten us," says Dr. Wilkins. "He attends our state and local functions, reports to us on issues and seeks our input."



John J. Ring, M.D.

A board-certified family physician, Dr. Ring was a JCAH commissioner until 1988. He currently serves as a delegate to the World Medical Association, where he chairs the committee on medical ethics. He is a former board member of the Illinois State Medical Society, and former president of the Lake County Medical Society. An assistant clinical professor of medicine at Chicago Medical School, Dr. Ring received his M.D. from Georgetown University. ▲

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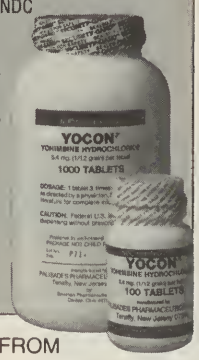
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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ISMS boosts nominees for top AMA offices

Illinois physicians and students are candidates for American Medical Association (AMA) leadership positions this June at the AMA's annual meeting in Chicago.

AMA Hospital Medical Staff Section

Joseph L. Murphy, M.D., a Chicago internist, is a candidate for the AMA Hospital Medical Staff Section's (AMA-HMSS) governing council. The AMA-HMSS was established in the early 1980s to allow hospital medical staff representation in AMA policy-making deliberations. The AMA-HMSS will meet June 15-19, 1989 at the Chicago Marriott Hotel. The election will occur Saturday, June 17, at 1 p.m. Dr. Murphy, who represents Chicago's St. Joseph's Hospital, has been the section representative since the AMA-HMSS was created. Illinois hospitals elect representatives from their medical staffs to attend this important meeting.

According to Silvana Menendez, M.D., a Belleville psychiatrist who chairs the Illinois HMSS, "We're making an all-out effort to make sure that Illinois provides a large number of votes for Dr. Murphy." For information on how to register for the meeting, contact ISMS-HMSS staff at 1-800-782-4767 or the AMA-HMSS staff at 312-645-4757.

Resident physicians

Bruce Doblin, M.D., an internal medicine resident from Chicago, is running for vice chairman of the AMA Resident Physicians Section's (AMA-RPS) governing council. Dr. Doblin has been a member of the state society's RPS governing council and is its immediate past chairman. In June 1988, he was elected an at-large member of the AMA-RPS governing council.

Andrew M. Basile, D.O., an emergency medicine resident from River Grove, is a candidate for at-large member of the AMA-RPS governing council. He currently chairs the ISMS-RPS governing council and is a member of the ISMS governmental affairs council. The RPS election will be held Saturday, June 17, 1989.

Students

William A. McDade, M.D., a University of Chicago Pritzker School of Medicine student, is a candidate for re-election to the AMA Medical Student Section's (AMA-MSS) governing council. Dr. McDade has been active in the Chicago Medical Society's student branch and the ISMS-MSS. He was elected to the AMA-MSS governing council in June 1988, and subsequently appointed vice chairman. The election for the MSS will be held on Sunday, June 18, 1989. ▲

Apply early for temporary license, staff advises resident physicians

by Franklin J. Kourt

PHYSICIANS planning to start a residency program in the state of Illinois on July 1 should already have had their applications for a temporary license into the Illinois Department of Professional Regulation (IDPR) or risk starting late.

According to Pat Eubanks, IDPR's assistant section manager, of the health services section, the state cannot guarantee that a temporary license will be issued on time if the application hasn't been submitted at least 60 days prior to the start of the residency program in which the applicant is enrolled. Since most residency programs start on July 1, this means the application should have been submitted by May 1.

She said applications are sometimes submitted two weeks prior to the training date, with the applicant expecting to begin on July 1, but this is not realistic, adding that following the 60 day rule is an especially good idea for students who are non-domestic graduates because it takes time for the necessary documentation to arrive.

"It can be done within 60 days but it has to be started at least that amount of time in advance or the forms will not get here in a timely manner," said Eubanks, who is the department's liaison to the state's medical licensing board.

She said that there are many things that can hold up the processing of a temporary license application, including securing transcripts from other countries, as well as the need for documentation of a name change that may have occurred due to marriage or divorce prior to submitting the application. In such a case, the applicant would be expected to submit a copy of the marriage or divorce certificate to document the change.

Eubanks also recommended that those submitting applications read the instructions very carefully and take care to submit all pertinent documentation and be sure the hospital follows up wherever necessary to avoid delays. "The profession has become so complex that we cannot determine if they meet educational qualifications from just a set of transcripts," Eubanks explained.

While it may be only one document that is holding up the issuance of a temporary license, IDPR is obligated to ensure that all requirements for licensure are met before one can be issued.

Eubanks emphasized that a major concern for those awaiting a temporary license is to be sure one has been issued to the institution where the residency program will begin before starting that program. Going ahead without one would constitute practicing medicine without a license and that can lead to very serious problems for the physician.

Although the individual physician is responsible for obtaining the temporary license, it is actually issued to the institution for which the physician will be doing the residency.

"The person holding the license is never in possession of it, it's always with the hospital," Eubanks explained. Therefore, it is the responsibility of the individual physician to make sure that the license has been issued to and received by the institution before beginning a residency program there.

She warned that those discovered practicing without a license can be disciplined by being placed on probation and once any kind of disciplinary action such as that happens, the information is entered into a national data bank. That, in turn, can result in lengthy delays in getting a permanent license to practice medicine.

Eubanks said such violations are often discovered when the physician applies for a permanent license and records show a discrepancy between the date he or she started the residency program and the date the temporary license was issued.

Experiences as to whether requirements for temporary licensing cause problems for residency directors vary with the individual director.

Bruce Becker, M.D., chairman and program director of the department of family practice at St. Mary of Nazareth Hospital Center in Chicago, said that in the past he has had occasions where a doctor had to postpone the beginning of his or her residency program because the temporary license hadn't come through on time.

"Last year it seemed more problematic than others. I'm hoping that this year, as the state said, it will be fairly well straightened out. The state has said that as long as we get our documents in by April 30, we'll have licenses for our residents by June 30. That's a 60 day turnaround, which would be great," Dr. Becker said.

Like Eubanks, Dr. Becker cited special problems for students who attended medical school outside the United States. "It really depends if the applicants can get the documentation they need, especially the foreign medical grads who need to obtain certification from their dean regarding their training as well as the clinical rotations they did at university-affiliated hospitals. Some of those folks will just have to spend the time or the money in order to get that information from Europe or the Middle East or the Far East or wherever they went and sometimes that's a hangup."

He said it's not likely these days that anyone would be allowed to begin a residency unless a license has been issued. "I think directors all know that they cannot allow a resident to see any patient unless they have a license. I think they're fairly well educated now so that will be a very, very rare occurrence."

He added that he hopes that one day state-of-the-art communications technology may shorten even further the waiting time it takes for issuance of a temporary license.

"I hope that in the future with the automation available today through communications, that the state would develop some sort of program to fax documents directly to the center and that would take out a lot of the delay as far as the mails. You can get a document there now in seconds rather than in three to five days and, of course, notary publics have now come up with an ink stamp to do their documentation. You could still get the same document notarized over a fax line to the state in minutes and then if there's any hangup they can fax you right back and say, 'look, the file's not complete. There's this, this and this,' and you're set. Hopefully that may be a speed of light type of transmission we can work on," Dr. Becker said.

According to Fred Z. White, M.D., residency director of the University of Illinois College of Medicine at Peoria, tardiness of applications for temporary licenses is not an issue there because the institution becomes involved very early in the process.

"It has not been a problem with us. We start as soon as we know what the match is. We begin to seek information at that time from them for all the material that is required in licensure and we get it right away, so we've not had any problem in getting the temporary license back. I think there's adequate time if one gets right at it," said Dr. White, adding that his institution asks the applicant to send the material needed for licensure almost immediately after a match is made.

However it's done, the message to would-be residents is clear: Get your application in early and be sure the institution has your temporary license in hand before starting your program. ▲

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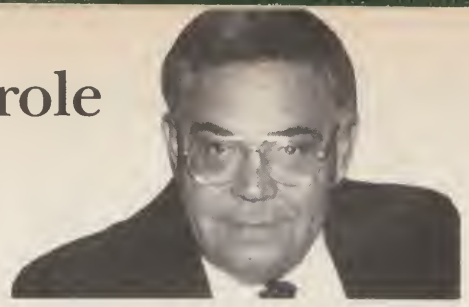
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The Physician's role in the political process



George T. Wilkins, Jr. M.D.

Contributing to IMPAC, the Illinois State Medical Society Political Action Committee, is not the only way that Illinois physicians can influence elections of Illinois public policy makers. In the following interview with Illinois Medicine, *IMPAC chairman George T. Wilkins, Jr., M.D., talks about some others.*

IM: *Why is it important for physicians to become politically active at all?*

GW: First, as physicians, we are fortunate to be able to play a leadership role in our communities. When we do not become politically active, we abdicate that leadership role, as well as a portion of our rights as citizens. Second, our place in the community obligates us to give back to the community some of the things we've been blessed with. Participation in the political process is one way to repay that debt. Finally, since the passage of Medicare/Medicaid in the mid-1960s firmly established government in the practice of medicine, physicians have a responsibility to help influence the substantial amount of medical legislation that becomes law every year.

IM: *IMPAC exists to raise and distribute funds to political candidates who are sympathetic to organized medicine. How does IMPAC select the candidates to whom it contributes?*

GW: IMPAC contributions are subject to recommendations from physicians at the local level because they are the ones who best know the candidates. All recommendations are considered by the 30-member IMPAC Council that meets quarterly to discuss IMPAC activities. The Council's five-member executive committee is also empowered to authorize contributions on short notice, when appropriate. The Council, in consultation with ISMS staff, determines the amount of each contribution.

IM: *Aside from contributing to IMPAC, what else should physicians do?*

GW: Find a candidate you like—be it for the school board, park district, alderman, mayor, state legislator, congressional race, whatever—and get directly involved in his or her campaign. Actually get down into precinct polling, running or working in phone banks, or helping in the "lickem' stickem" mailings that are a part of any campaign. You know, physicians' offices make the best phone banks around because

(continued on page 13)



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Physician thrives on working in politics



Edward T. Ragsdale, M.D.

"It's interesting, it's the people's work," said radiologist Edward T. Ragsdale, M.D., of Alton, about the necessity of involvement in the political process. "If we don't get involved, somebody else, maybe less qualified, is going to be running our business."

He began as a Republican precinct captain in St. Louis more than 20 years ago, and has served as both a county and state committeeman. He was chairman of the Madison County Republican Committee from 1976 to 1986, and has been a state committeeman since 1986. He attended the last three Republican national conventions, twice as a delegate.

Dr. Ragsdale has contributed his talents to the Illinois State Medical Society (ISMS) as well. At various times since 1976, he has served on the Government Affairs Committee and the Public Affairs Committee. He currently serves on the IMPAC Council.

Dr. Ragsdale firmly believes that getting to know legislators can produce results. He is confident that his relationship with three legislators who represent his area was helpful during the ISMS push to pass the recent tort reforms. "You establish a personal relationship and help a person become elected, they're going to listen to you," he said.

Dr. Ragsdale said that Illinois physicians were very impressive in the effort to pass the malpractice reforms. "Many of us went to Springfield and in a very effective way lobbied our legislators to get some relief." However, he cautions that the job is not over. He also wishes more physicians would get involved in the process.

"I've felt for a long time that the people who are the most able tend to stay away, and it's a shame," Dr. Ragsdale concluded. ▲

the lines are already installed. It isn't that expensive and it can be a big help to a candidate whose campaign is short on cash.

Also, talk to your patients. As a pediatrician, I've been talking to mothers, and occasionally a father, about the political process for years. I usually save my pitch until the end of the visit, but over the years I've found that patients accept it quite well. Sometimes, it can backfire, however. I remember one year I was involved in a local legislative race and stuffed some campaign notices into patient bills. It turned out that one of my patients was the opposing candidate. He told me, "You're a hell of a good doctor, but you're a damn poor politician!" On the whole, however, I've found patients are receptive.

IM: *Can physicians become involved more substantively in a politician's campaign? For example, can they help a candidate determine positions on medical matters?*

GW: Absolutely. Physicians and their spouses can be valuable resources for the candidate. Invite the candidate to talk to you about his positions on health care issues. You may find out he hasn't yet clarified his position in his own mind because he may not understand the issues. Now, you have an opportunity to educate him. If he does not yet have a committee working on a health care issues paper, volunteer to form one and write it for him. Even if you aren't successful in getting the candidate to adopt your position, you've started the all-important education process that can be crucial down the road.

IM: *Can you think of some physicians in Illinois who are already politically involved along these lines?*

GW: In the Edwardsville area, we have nine or 10 young family practitioners who are driving forces in their community. One of them served as president of the Madison County Medical Society a year ago. The spouse of another helped run the campaign of the head of the high school's art department in his race for mayor. He beat the 72-year-old incumbent by about 2-1. In fact, you'll find that downstate if you want to have a successful practice, you have to have visibility in your community.

Moreover, in Alton, radiologist Edward Ragsdale, M.D., was chairman of the Madison County Republican Party and was recently elected the congressional committeeman. Politics is certainly more than a hobby with Ed, it's almost a profession. He has become a good role model for the physicians in my area.

IM: *Any final thoughts?*

GW: Only that becoming politically involved is being a good citizen, and we hope that more physicians will take the plunge. We need to make changes, and if we're going to do so, we have to make them from within. ▲

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(continued from page 2)

profession, "we hesitate to allow licensing of an independent practitioner where the quality of care might suffer. We favor setting national professional standards and certification, rather than licensure for certain paramedical areas which should not be independent of medical practice."

On March 29, the Illinois Supreme Court ruled unconstitutional a 1986 conviction of a Makanda woman for practicing midwifery, on grounds that the law did not define what midwifery meant. The woman had been charged and convicted with practicing midwifery without a license when the baby she helped deliver died shortly after birth. Two other downstate midwives are charged with practicing medicine without a license following a fatal home birth last year.

A rural Illinois resident, Dr. Johnson emphasizes the need for hospital care with physician backup during childbirth. "There isn't any place to my knowledge within southern Illinois where adequate medical care is not available within a reasonable time limit, provided you have a method of transportation to the service. If a patient has been screened for possible problems that might arise during childbirth, the course of events should be managed, so she is transported prior to the development of any complications," he says.

Nurse specialists

Meanwhile, registered nurses would be allowed direct insurance reimbursement for services they're qualified to provide, and certain advanced nurses would be allowed prescriptive powers, under two bills sponsored by Reps. Jesse White (D-Chicago) and John Dunn (D-Decatur). According to the Illinois Nurses Association (INA), nurse specialists include certified registered nurse anesthetists and nurse midwives, clinical nurse specialists and nurse practitioners.

An INA spokesperson says, "prescriptive privileges for advanced nursing specialists would allow more patients to be treated while eliminating the potential for second-class care."

ISMS opposes authorizing nurses to diagnose illness and prescribe drugs, based on their lack of proper education and training. Both House bills were placed in interim study.

Medical assistants

On a more cooperative note, both ISMS and medical assistants favor a bill introduced by Rep. Gordon Ropp (R-Bloomington) that would ensure the right of the physician to delegate duties to office-based medical assistants. Current law makes no reference to medical assistants—under the Nursing Practice or Medical Practice Act. Medical assistants thought it important that Illinois law distinctly separate their role in the medical office from that of nurses.

"If a judge were asked to strictly interpret the statutes of the state, the ambiguity could disrupt the practice of medicine by jeopardizing the jobs of thousands of medical assistants now employed by physicians," says Donald Balasa, American Association of Medical Assistants legal counsel and assistant executive director.

The bill would add medical assistants to the list of exemptions from the licensure requirements of the Illinois Nursing Practice Act. It also states that procedures by medical assistants could be done in outpatient settings such as doctors' offices, medical clinics and ambulatory treatment centers. The bill is on the House floor on third reading as of May 17, 1989.

Social workers vs. psychiatrists

Clinical social workers are also pulling full speed ahead in Springfield to obtain independent health insurance reimbursement.

The bills amend the Illinois insurance code by adding licensed clinical social workers as a health care professional patients may choose for coverage of mental, emotional or nervous conditions. The proposal mandates payment for such services by the insurer. Currently, only physicians "licensed to practice medicine in all its branches" and registered clinical psychologists are covered.

Julie Hamos, National Association of Social Workers' legislative representative claims there are not enough psychiatrists available in Illinois counties. "Do people really travel to a totally different county just to get help?" questions Hamos.

ISMS has worked with the Illinois Psychiatric Society (IPS) to oppose these bills, H.B. 748, sponsored by Richard Mautino (D-Spring Valley), and S.B. 577, sponsored by Emil Jones (D-Chicago). According to a recent American Psychiatric Association study, most counties have a psychiatrist available in an adjacent county.

"While social workers are competent to provide care for which they are trained, many patients, including elderly and psychiatric patients, have physical disorders requiring medical evaluation before health resources are expended. A medical differential diagnosis is mandatory, along with effective overall care. This can be done only by physicians," says David R. Hawkins, M.D., IPS immediate past president.

Larry Barry, president of the Illinois Life Insurance Council warns that social worker reimbursement will increase costs. "Everytime we add a new provider to insurance policies—clinical social workers or anybody else—it increases costs and utilization. The bill is on the floor of the House on third reading as of May 17, 1989. ▲

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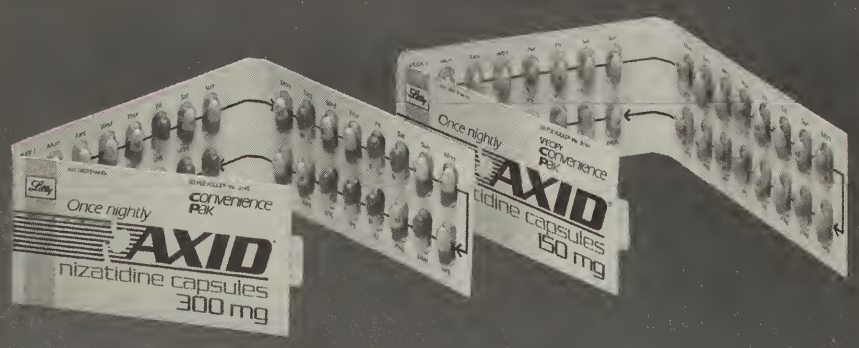
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Brief Summary
Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.
Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.
3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.
Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.
Drug Interactions – No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.
Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.
Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.
In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.
Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.
Pediatric Use – Safety and effectiveness in children have not been established.
Use in Elderly Patients – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.
Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.
Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.
CNS – Rare cases of reversible mental confusion have been reported.
Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.
Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.
Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.
Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.
Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.
Signs and Symptoms – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.
Treatment – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.
If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

PUBLIC HEALTH REPORT

St. Louis encephalitis may cross Illinois border

IT MAY be time for an outbreak of St. Louis encephalitis, warns the Illinois Department of Public Health (IDPH).

This mosquito-borne disease occurs roughly every 10 years in Illinois, IDPH-infectious disease experts say. The last outbreak occurred in 1975. There were approximately 575 cases and 45 deaths. Since then, there have only been a small number of cases with only one reported in DuPage County in 1988.

The mosquito that transmits St. Louis encephalitis is a dawn-to-dusk biter and breeds in standing water that contains decaying organic matter, such as water found in drainage ditches or flower pots. IDPH officials also warn that the mosquito carrying California encephalitis breeds in a similar way, though it is a daytime biter and the resulting disease is more likely to affect children ages 4 to 12.

The diagnosis for either St. Louis or California encephalitis can be established by taking acute and convalescent serum specimens two weeks apart. IDPH labs will analyze the specimens free of charge for physicians or hospitals.

These arthropod borne viruses are just presenting a risk this month in southern Illinois, but will be at peak risk of infection by July and August throughout the state, IDPH advises.

Spring can trigger fungal infections

SPRINGTIME is also the time to be on the alert for sporotrichosis, IDPH says.

Illinois' major 1988 outbreak of this fungal infection was part of a national one, according to IDPH officials.

Physicians may see the infection more often than diagnose it, IDPH said. Be suspicious if your patient has a history of horticultural contact, particularly with trees packed in sphagnum moss or with rose bushes. Last year's outbreak was tied to the moss surrounding fir trees from a tree farm in Tennessee that sold its product nationwide.

Physicians should also be suspicious if the patient has skin ulcers that do not heal or respond to conventional antibiotic treatment. Often there is swelling of the lymph glands in the area affected. The incubation period is several weeks, so physicians may see cases anytime throughout the summer. Two cases have already been reported to IDPH—one a holdover from last year's outbreak and just diagnosed this year.

Rheumatic fever recurs

A RECURRENCE of acute rheumatic fever is being reported in Pennsylvania, Ohio, Utah and Massachusetts, according to the program council of the American Heart Association of Metropolitan Chicago. In a recent advisory, the council alerted Illinois physicians to the "recrudescence" of rheumatic fever, noting that "in any community in which even a single case of acute rheumatic fever has occurred, a short course of oral penicillin for group A streptococcus infection may be inadequate. Benzathine penicillin G is the treatment of choice, since it has been demonstrated to curtail outbreaks of rheumatic fever. Recommended doses are 1.2 million units for patients weighing more than 60 pounds; and 0.6 million units for patients weighing 60 pounds or less, administered by a single intramuscular injection. Erythromycin should be prescribed for individuals who are allergic to penicillin."

Measles outbreak slows

THE MEASLES outbreak at Bradley University in Peoria seems to be over with 105 confirmed cases. The rest of Illinois continues to see sporadic outbreaks.

As of May 11, there are 342 confirmed cases of measles, primarily among junior high and high school students in DuPage, Kane, and McHenry counties. Auburn High School in Rockford has been hard hit, but only isolated case reports have surfaced in Cook County, with nine cases at Northwestern University. There are seven reported cases at Trinity College.

Ferret attacks reported

European ferrets, increasingly popular as house pets, are worrying public health entities. According to a 1988 California Department of Health Services monograph reprinted and distributed by the IDPH, ferrets can unleash "frenzied, rapid-fire bite and slash attacks," particularly on unattended infants. Although California has banned the weasel-like animals as domestic pets since 1935, that state is among 18 reporting 452 ferret attacks spanning 1978-1987. Among these were 63 unprovoked attacks, including several near-fatal episodes on infants and small children. ▲

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Dr. Kremper was a practicing OB-GYN until April of 1988 when illness forced the then 45 year-old physician to retire from practice.

Although he had been an APIC policyholder for less than a year, Dr. Kremper was given "tail coverage" at no charge due to his disability. This provision in his APIC policy saved Dr. Kremper over $119,000, and allowed him to enter his retirement with the knowledge that he would have coverage for future claims that might arise from his former practice.

Furthermore, since he had purchased APIC's "prior acts" coverage in lieu of a tail policy from his previous commercial carrier, Dr. Kremper will be fully protected for all claims that might arise from treatment dating back to July 1 of 1982 – the date he purchased his first claims-made policy from the commercial carrier.

Dr. Kremper describes his situation:

"It was difficult for me to accept having to stop my practice of medicine. But with my APIC policy still in force, I at least knew I wouldn't have to worry about what might happen if I were to get sued after I retired. And it was a big relief knowing that I didn't have to come up with an extra $119,000 in premium."

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Legislation

(continued from page 3)

jor reason for the departure of obstetricians from sparsely populated counties in southern Illinois. Many general or family practice physicians have given up the obstetrics portion of their practices.

Other legislation in the Senate package would allow counties to set up regions to provide rural ambulance services, and would provide income supplements to nurses working in hospitals and nursing homes in communities of 50,000 or fewer population.

Legislation allowing IDPH to establish a program expanding comprehensive primary care in medically underserved communities also awaited final Senate action last week. Assistance would include financial and technical aid. However, the services must not duplicate resources in areas already served by community health centers.

Funding for the rural health care program would be raised by earmarking the privilege tax paid by out-of-state insurance companies that do business in Illinois. State income tax payors also would be allowed to earmark part of their refund payments for the community health center fund.

Withdrawal of nutrients . . . Legislation seeking to control withdrawal of nutrition and liquids from terminally ill patients was rejected by the House Judiciary I committee. Two related measures restricting conditions under which nutrition and hydration could be withdrawn from a patient, or not started at all, attracted ISMS opposition. A special attempt to discharge the legislation to the House floor over committee objections also failed. The Illinois Catholic Conference and the Chicago Bar Association also opposed the measures, although supporters tried to posture them as right-to-life issues.

H.B. 646, sponsored by Rep. Thomas McCracken (R-Westmont) was one of the defeated bills. It would have barred discontinuing nutrition and hydration unless the patient had executed a living will, specific to the circumstance, had assigned power of attorney to a specific person to act on his or her behalf with regard to nutrition and hydration, or while still competent had directed that such steps not be taken to prolong life. The bill also directed that medical and hospital authorities could discontinue or withhold nutrition and hydration only if: administration would cause significant pain that could not be relieved; the nutrients could not be assimilated; the process would shorten instead of prolong life; or if death were imminent.

H.B. 924, the second bill rejected, was also sponsored by McCracken. It would have required that living wills and power of attorney documents include specific instructions on withholding nutrition or hydration in order for the patient's agent to act. It also would have limited the agent's power to order an abortion.

Senate efforts to move similar legislation to the full floor for consideration also failed.

Standards for determination of death . . . In other action, legislation legally defining death received committee approval and advanced to the full House. H.B. 611, sponsored by Rep. Grace Mary Stern (D-Highland Park), would set a standard for determination of death. Irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, would constitute death, according to the bill. Similar legislation, S.B. 68 sponsored by Sen. John D'Arco, Jr. (D-Chicago) has passed the Senate.

Addicted babies . . . Also awaiting final Senate action were bills designed to provide treatment for drug-addicted women who become pregnant.

One of the bills would establish a program for the care and treatment of addicted pregnant women and addicts with children under the age of two. Drug abuse education would be required for women enrolled in public aid's Women, Infant and Children (WIC) program. ▲

State

(continued from page 1)

American Federation of State, County and Municipal Employees, representing 75,000 members statewide. He explained that several union members have complained to his office that physicians and other providers are "using aggressive techniques, including collection agencies," to get paid by state employees. "While funding should have been provided at proper levels, it is wrong for providers to go after employees when they're going to be paid eventually."

Physicians may be tired of waiting for payments, but they should not bill patients themselves, Thornsen advised. "It will just double the physician's paperwork because as soon as we issue a check, he [or she] will have to refund the patient for any payment received. We're asking physicians to be patient."

In the meantime, physicians heavily affected by the payment delays may have to contemplate taking out loans to cover their expenses, explained Jane Jackman, M.D., ISMS Fifth District Trustee. "Doctors won't turn patients away, but we must continue to pay our employees and meet overhead costs, [while the] state is getting use of interest-free money owed to us," she said. It doesn't seem to matter whether the patient is under an indemnity plan or an HMO, she noted. "Either way, the doctor is getting hurt." ▲

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Daley appointees

(continued from page 1)

care services to all our communities."

The appointments include Northwestern Medical School Professor of Medicine Whitney W. Addington, M.D. as board president. Richard M. Krieg, Ph.D., associate dean for administration at the University of Illinois School of Public Health, will serve as interim commissioner. All appointments are subject to city council confirmation.

"His vast knowledge of public health issues will help guide this board towards a more complete, more efficient health care service," Daley said of Dr. Addington. The mayor also said that Krieg brings "tremendous management skills to a department that desperately needs them."

According to Daley, the board's first job is conducting a nationwide search for a top-quality health administrator to serve as permanent commissioner. He said that Krieg could not serve as permanent commissioner because city ordinance requires the position be filled by a physician. Krieg has previously served as deputy commissioner of the Chicago Department of Health.

Chicago's health department has come under attack in recent years for the city's infant mortality rate, poorly-managed immunization and food inspection programs, and an inadequate response to the city's growing AIDS problem.

Daley told the new board their overall charge is to ensure an efficient and compassionate health care delivery system in the city. He instructed board appointees to consider various options for attaining this goal, including contracting for services with private entities such as hospitals.

Saying that the city's public health clinics currently operate for the convenience of those who work in them, the mayor questioned the current practice of city clinics being open only from 9 a.m. to 5 p.m. Monday through Friday. "We have to find out why we're building these large public health clinics, but not servicing the communities."

Dr. Addington, who co-chaired the indigent health committee of the Metropolitan Planning Council for the past five years, said that although the health commissioner's currently budgeted $85,000 salary is "fairly competitive," the board may increase it. He also said access to quality prenatal care for medically indigent mothers is a major need. Dr. Addington indicated the board would have more to say on this and other health care issues in the coming weeks. Its first meeting is slated for May 17.

A graduate of Northwestern Medical School, Chicago, Dr. Addington is a chest physician with a particular interest in tuberculosis. From 1984 to 1988, he served as governor for the American College of Physicians, northern Illinois chapter.

The mayor's other appointments to the board are:

Edward F. Lawlor—An assistant professor at the University of Chicago's school of social administration, Lawlor is a leading AIDS researcher in Chicago's academic community. He is currently the principal investigator for a hospital closures research project funded by the Prince Charitable Trust and the Chicago Community Trust.

Sister Sheila Lyne—Currently president of Mercy Hospital and Medical Center, Sister Sheila helped engineer innovative health service programs, including direct service contracts that enable Mercy to serve low-income, public health patients in need of acute care services. She has served in a variety of community service capacities.

Iris Shannon, R.N., Ph.D.—Shannon is associate professor at Rush University college of health sciences and current president of the American Public Health Association. She has made three study tours to the People's Republic of China to examine that country's health services, with an emphasis on nursing. She received her Ph.D. in public policy analysis from the University of Illinois at Chicago.

Toni Miles, M.D., Ph.D.—Dr. Miles is a lecturer in the department of epidemiology at the University of Illinois at Chicago's school of public health and is also on staff at the Illinois Geriatric Education Center. She has also served with the National Institute on Aging, and as a grant reviewer for the Minority Community Health Based Coalition Demonstration Grant Program operated by the office of minority health in Washington, D.C. She received her M.D. and Ph.D. in anatomy from Howard University.

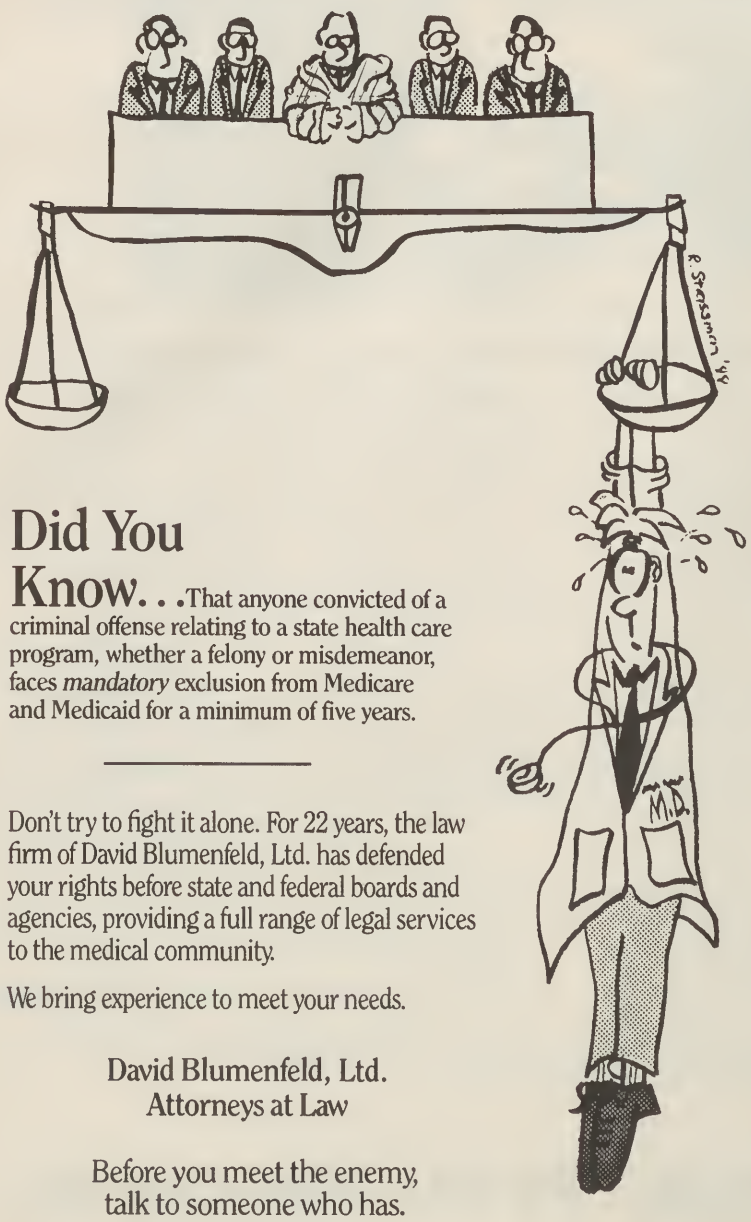
Donald Hopkins, M.D.—Dr. Hopkins is an international authority on infectious diseases, and was active in the eradication of smallpox. He currently serves as a consultant to the Carter Presidential Center in Atlanta. His resume includes posts as acting director, Centers for Disease Control and assistant surgeon general. He received his M.D. from the University of Chicago's school of medicine and his M.P.H. from Harvard University.

Carmen Mendoza—Mendoza is executive director of the Claretian Medical Center of South Chicago and serves as an ex-officio member of the mayor's advisory committee on infant mortality. She is responsible for the administration of two primary care facilities in the south Chicago and Roseland communities, and is a former member of the Board of Health.

Ashok Raojibhai Patel, M.D.—Dr. Patel is chairman of the division of hematology at Cook County Hospital. He has been involved in a variety of indigent health care issues, as well as issues relating to AIDS patients. He has also done extensive research on sickle cell disease. He received his M.D. from Seth G.S. Medical College, Bombay, India (Bombay University).

Susan Manilow—Manilow is vice president and director of Family Focus, a not-for-profit family support agency that works with teen parents and with teens at risk of becoming parents. She is a former member of the Illinois Council on Aging, and now serves on the committee of 100, organized by Voices for Illinois Children. Manilow also serves as a trustee of Mt. Sinai Hospital and Medical Center. ▲

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Illinois Medicine

June 9, 1989

ILLINOIS STATE MEDICAL SOCIETY

Class action suit filed to stop U of I/ Reese merger

by Kevin O'Brien

A CLASS ACTION lawsuit to stop the proposed University of Illinois/ Michael Reese Hospital and Medical Center/Cook County Hospital (CCH) affiliations was filed May 24, but not announced until *Illinois Medicine* was going to press on May 31. Named as defendants are the nine members of the university's board of trustees and university president Stanley O. Ikenberry. Plaintiffs include Donna Harper and Elva Michel, two indigent patients of the University of Illinois Hospital (UIH), as well as the Northwest Austin Council and the Tri-Taylor Conservation Association on behalf of their respective members.

The suit alleges that UIH medically indigent patients will have no place to go if CCH leases UIH as provided for in the affiliation agreements. The suit claims that CCH is currently medically understaffed, and that a majority of current UIH medical staff "will not seek or receive employment at CCH." It further claims that even if CCH recruits replacements, an additional $50 million not included in the county's budget is required to pay them. Consequently, the suit alleges that implementing the agreements will deprive medically indigent patients of "necessary medical care and treatment and access to medical services."

Plaintiff attorney John L. Gubbins said that he will either seek a permanent injunction to halt the affiliation, or else to modify the proposed agreements to address the needs of UIH indigent patients. Noting that the Illinois Senate is now considering implementing legislation, he said he will file a motion to expedite the case and expects a hearing the week of June 5. A university spokeswoman said that university policy precludes

(continued on page 17)

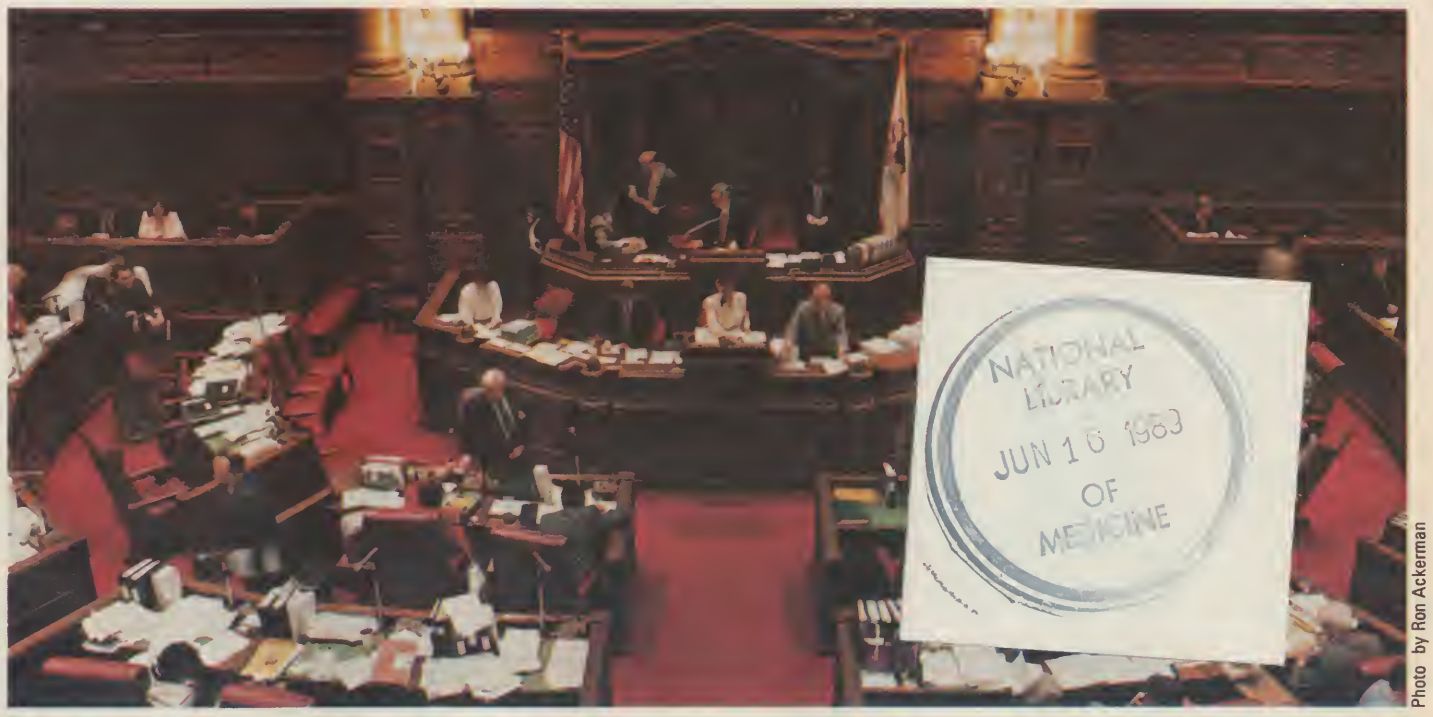


Photo by Ron Ackerman

Illinois Senate floor action was in full swing last week, as major bills affecting health care came under consideration. Among them, a measure to pass mandatory Medicare assignment for physicians went down to defeat.

Senate kills mandatory Medicare assignment

by Caryl Carstens

MANDATORY MEDICARE assignment was decisively defeated by a 39-15 vote in the Senate May 26, and similar House legislation was placed in interim study.

"We're delighted that Illinois lawmakers realized mandatory assignment would wreak havoc on medical care for Illinois seniors," said Illinois State Medical Society (ISMS) President Eugene P. Johnson, M.D. He noted that Medicare patients in Illinois are already paying some of the lowest rates for physician care of any age, social or other demographic group. "Legislators from both parties who opposed S.B. 294 recognized that," he said, "and we commend them for standing up to a lot of pressure."

While the proposal appeared to be dead for this session, legislative watchers warned it still could be revived by amendments to other bills or some other parliamentary device before the General Assembly adjourns for the summer at the end of June.

Backers of the legislation aren't ready to quit.

"We're certainly exploring our options," said Jan Schakowsky, executive director of the Illinois State Council of Senior Citizens' Organizations, which has campaigned for passage of the legislation since last December.

"We haven't given up on addressing the issue of doctor overcharges," she added. She saw the defeat as evidence of the "inordinate power of the Illinois State Medical Society" over legislators.

"There is no question in my mind that Illinois physicians will be accepting mandatory assignment," said Schakowsky. She reported the issue is being raised in more and more states, and she believes there is movement on the national level that will result in mandatory assignment.

Specifically, elderly representatives elsewhere are seeking mandatory assignment for charges of anesthesiologists and similar types of specialists, she said. A gradual lowering of the maximum charge allowed under Medicare until it reaches the level of assignment also is being pushed, according to Schakowsky.

Senate mandatory assignment sponsor William Marovitz (D-Chicago) said that he might revise the bill to include a means test so that it would "not apply equally to millionaires," and would consider reintroducing the revised version next year.

While the Council worked hard for

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Indigent care summit debates alternatives; no consensus yet

GOVERNOR THOMPSON'S health care summit met for the second time Thursday, May 25 to discuss potential solutions to Illinois' indigent care problem, but failed to find consensus on a specific plan for state legislative consideration before the General Assembly's scheduled June 30 close.

Appointed by the governor earlier this year, summit members have studied issues ranging from how to fund health care for Illinois' uninsured to assuring access to and quality of care for the state's Medicaid recipients. The group is comprised of more than 30 Illinois health care, civic, business, labor, insurance, public health and legislative officials.

"We're not disappointed," said Jeff Miller, the governor's chief of staff, about the summit's inability to lay out solutions in time for legislative consideration this year. "The good news is that people are still willing to talk."

Miller predicted that the legislature might "chip away" at the indigent care issue before adjourning. "The whole issue of Cook County/University of Illinois/Provident hospitals will be debated this session," he said. He also cited current bills expanding Medicaid eligibility and boosting reimbursements to hospitals treating a disproportionately large share of public aid patients.

The summit's working groups will continue to work over the summer months toward further fleshing out answers. Miller targeted the governor's fiscal year 1991 budget proposal, due out in March 1990, as a probable vehicle to promote any indigent care recommendations.

Summit: Medicaid funding scarce

The summit heard reports from three of its four subcommittees charged with developing specific proposals on Illinois' indigent care problem. One common thread running throughout all three was the currently inadequate funding level supporting Illinois' Medicaid system. "There was very little disagreement on the need for more funding," characterized Edward Lawlor, University of Chicago assistant professor and chair of the summit's state payment system advisory group. "Across the board, there was concern about the funding supporting this system," he said. "Within such constraints, it's hard to be innovative."

Miller characterized the Medicaid reimbursement issue as one that "has to be addressed." He added a note of caution that "some of the summit participants were reluctant to endorse even that without being aware of where the dollars would come from. It's not enough just to put more money into the health care system, without figuring out what the money is going to buy," he said.

Beyond the fragile funding consensus, the summit made little progress in melding participants' divergent views into specific solutions. Two of the three working groups presenting reports did little more than agree on principles, related Alexander R. Lerner, Illinois State Medical Society (ISMS) executive vice president, a summit member. "There just wasn't time to delve into the complexities of this issue in such a short time frame."

Lerner said the third working group, which looked at access and quality care for indigent patients, proposed such radical managed care and regulatory oversight schemes that many Illinois doctors currently serving Medicaid patients would have been essentially driven out of the system. "That's not acceptable," he said. "A whole new Medicaid plan to expand access to care and regulate its quality, without thinking about the impact on doctors already treating the bulk of Medicaid patients at a monetary loss, doesn't make any sense. I hope we disabused the summit of that notion," he emphasized.

The fourth and final summit working group, charged with making recommendations on ways to develop and market Chicago as a world class medical center, had not yet met by May 25. That group is expected to work over the summer and offer its views at a later summit.

Below is a summary of the three reports presented.

Health insurance for the uninsured

This group's assignment was to "study ways to provide access to nec-

(continued on page 18)

Medicaid funds: playing politics

While the indigent care summit might have reached general consensus on the need for new Medicaid funding to increase provider reimbursement, Illinois House Speaker Michael Madigan (D-Chicago) does not seem to have this high on his priority list. In a surprise move, Madigan announced a temporary, two year income tax hike to raise $726 million for the 1990 fiscal year beginning July 1. He previously stood opposed to any increase.

Funds raised by Madigan's proposal will provide only "much needed financial assistance for education and local governments throughout the state," according to a news release issued by his office.

Governor Thompson's proposed 1990 budget—not yet approved by the Illinois General Assembly—provides limited new monies for shoring up Medicaid programs, such as obstetrical care, in especially dire straits.

The House passed Madigan's tax plan immediately after he proposed it. It now awaits Senate floor action, where more debate on additional needs could foretell some changes.

Whether that means more Medicaid funding for physicians remains to be seen. It is clear that Medicaid does not currently have a political constituency able to generate support for the necessary tax increases. Discussions about new Medicaid funding could include "strings" attached to those dollars. ▲

House bill seeks protection for retirement funds

PROTECTING PHYSICIANS' retirement funds from being wiped out by a large medical malpractice verdict is the objective of legislation currently making its way through the Illinois General Assembly. H.B. 247 would create a blanket exemption in bankruptcy proceedings for assets held in pension funds. Bankruptcy proceedings to liquidate defendants' personal assets can follow large jury verdicts. The measure covers all Illinois citizens—not just MDs.

The bill passed the House May 23 and awaits Senate action. A companion Senate measure failed to clear the Senate Judiciary Committee.

"Eliminating the threat of losing retirement assets makes defending physicians against charges of medical malpractice much easier," explained Illinois State Medical Insurance Services (ISMIS) Chairman Robert C. Hamilton, M.D. "Plaintiff attorneys often make huge monetary demands—well above the defendant physician's insurance policy limits—to prompt settlement of cases that are eminently defensible in court," he continued. "This puts a physician's personal assets—including any retirement nest egg—at stake, and thus drives a wedge between the physician and his or her defense counsel." He characterized the "scare tactic" as highly effective, adding "this is why physicians, and all citizens, need specifically to carve out the exemption."

The problem is a broad and troublesome one, according to Illinois State Bar Association (ISBA) lobbyist Dan Houlihan. ISBA is working with the medical society to promote this legislative remedy. "Retirement assets have been obtained by creditors in past bankruptcy proceedings," he noted. "This legislation is particularly important in multi-employee pension plans. You risk [losing] the qualification for a plan if just one of the members goes bankrupt."

Houlihan said that since an early-1980's oversight in the federal bankruptcy code, "the majority of court decisions [have] ruled assets are attachable to bankruptcy proceedings." Exemptions to this are, however, governed by state law. According to Houlihan, "a series of states have enacted similar legislation protecting pension fund assets" over the last several years.

House sponsor Rep. Lee Preston (D-Chicago) agrees the exemption is much-needed. "Individuals who spend their lifetimes saving for retirement should not be subject to relinquishing all because of business reversal, illness or a bad judgment against them." Other sponsors and cosponsors include John Matijevich (D-Waukegan), John Dunn (D-Decatur), Penny Pullen (R-Park Ridge), Larry Hicks (D-Mount Vernon) and Kurt Granberg (D-Centralia). Senate sponsors are Greg Zito (D-Melrose Park) and William Marovitz (D-Chicago).

Whatever the outcome of the legislation, having adequate liability insurance limits is a key ingredient to protecting personal assets from being taken to cover a court verdict, advised William Rogers, a partner with Wildman, Harrold, Allen, and Dixon. Rogers said plaintiff attorneys are more likely to pursue a physician's retirement and other personal assets when malpractice coverage is insufficient, "as opposed to a physician who has high policy limits. Plaintiffs and their attorneys may feel that the physician showed more concern for his or her patient in obtaining adequate limits, and that the amount of available insurance money is sufficient for client protection," he surmised. ▲

Physician Facts



Public Opinion Survey*

Would you favor or oppose withdrawing life support systems including food and water from hopelessly ill or irreversibly comatose patients if they or their families requested it?

Favor	73.5%
Oppose	16.5%
Not sure	10.0%

*A total of 279 adults from Wisconsin, Michigan, Illinois, Indiana and Ohio were interviewed in 1986.

Source of Data: *Physician and Public Attitudes in Health Care Issues*. American Medical Association, 1989.

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On the Legislative Scene

by Caryl Carstens



Smoking limitations . . . The Clean Indoor Air Act has been sent to the Senate after passage in the House. H.B. 120, sponsored by Rep. Robert Terzich (D-Chicago), was supported by ISMS, the Illinois chapter of the American Cancer Society, the Illinois Interagency Council on Tobacco and Disease, as well as other groups. The measure bans smoking in a broad variety of facilities, including educational institutions, hospitals and nursing homes. The bill also covers government agencies, and allows for home-rule in communities where more restrictive smoking regulations already exist.

A weaker bill, S.B. 527, sponsored by Senator Richard Luft (D-Pekin) and backed by the tobacco industry, was sent back to committee, but the measure could still be revived. The Senate passed S.B. 44, sponsored by Sen. Margaret Smith (D-Chicago), and sent it to the House. The legislation would prohibit smoking in health care facilities, doctors' offices and child care facilities.

AIDS testing . . . Abolition of the requirement for pre-marital AIDS testing has passed the House and awaits Senate action. H.B. 18, sponsored by Rep. Grace Mary Stern (D-Highland Park), would do away with the pre-marital syphilis test as well. ISMS supports the legislation.

H.B. 1878, sponsored by Rep. Penny Pullen (R-Park Ridge), also received House approval. The bill allows a doctor to notify a spouse of an AIDS test subject if results are positive. The legislation grants immunity to physicians who make such notifications in good faith. ISMS is not opposing the legislation.

In the Senate, S.B. 705 was passed as amended, authorizing the Illinois Department of Public Health (IDPH) to develop an educational program to reduce the prenatal incidence of AIDS. The sponsor is Sen. Margaret Smith (D-Chicago).

Death definition . . . A uniform definition of when death occurs lost when H.B. 611, sponsored by Rep. Grace Mary Stern (D-Highland Park) was defeated. The measure provided that a person is dead when irreversible cessation of circulatory and respiratory functions occur, or when the brain ceases to function. S.B. 68, a similar bill sponsored by Sen. John D'Arco (D-Chicago), passed the Senate, and awaits House consideration. Both bills had received ISMS support.

Informed consent . . . H.B. 506, sponsored by Rep. Monique Davis (D-Chicago), was approved by the House. The bill would require that a physician get a patient's informed consent to prescribe an FDA-approved drug for experimental purposes which may not have been approved by the FDA. The measure would apply when the patient is the subject of an approved research program or experimental procedure as defined under rules and regulations of the Hospital Licensing Act. Failure to obtain informed consent would subject a physician to discipline under the Medical Practice Act.

Immunity from liability . . . Legislation providing that a doctor shall not be liable when he treats a patient without compensation was passed in the Senate. S.B. 683, sponsored by Sen. John Maitland (R-Bloomington), makes one exception: immunity is not extended to doctors found guilty of willful and wanton misconduct. Rep. Frank Giglio (D-Calumet City) introduced similar legislation in the House on behalf of local physicians and ISMS. While the measure passed out of committee, it failed to pass the House.

ISMS has backed numerous "good samaritan" legislative initiatives to protect physicians providing free care. The liability issue emerged in the mid-1970s, when a Kane County physician established a free clinic following his retirement. After a lawsuit against him, legislators passed a "free clinic law," specifically limiting protection to those physicians who gain no other income from practicing medicine.

Physicians providing free care in emergency settings are protected under the 1987 Medical Practice Act. In addition, a recent Illinois Supreme Court ruling said that "good samaritan" protection also applied to physicians providing emergency care without compensation in *any* setting, including hospitals. The legislation under current consideration in Springfield would protect physicians working part-time in free care settings, and who maintain their current practices. ▲

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REPORT FOR *Illinois Physicians*

SAME-DAY ADMISSION FOR SURGERY

Numerous studies have confirmed the efficacy of admitting patients to the hospital on the same day that surgery is scheduled. Same day surgical admissions are entirely compatible with high quality care, and with the needs of house staff training programs. Same day surgical admissions have also been popular with patients, since they can spend the night before surgery in the comfort of their homes. The incidence of the need to cancel surgery, because the patient ate or otherwise did not properly follow instructions, is very low. Consequently, costs associated with admissions one or more days before surgery, will not be covered when we find that the early admission was for the convenience of the patient or the physician.

The following are conditions and procedures in which admission one or more days prior to surgery generally would be medically required.

1. Cardiovascular Surgery
   - — Coronary Artery Bypass Graft
   - — Aorto — Femoral — Popliteal bypass
   - — Repair of Aneurysm, Intra-Cerebral, or Aortic
   - — Cardiac Valvular Replacement
   - — Carotid Endarterectomy
2. Craniotomy
3. Organ Transplantation
4. The patient's medical condition requires inpatient treatment or stabilization before surgery. *Examples* of such conditions are as follows:
   - — Poorly controlled insulin dependent diabetes melletus
   - — Congestive heart failure
   - — Far advanced renal or hepatic failure
   - — Severe, current arrhythmia
   - — Required pre-operative blood transfusions, or administration of parenteral blood products
   - — Required adjustment of significant medications (anti-coagulants, steroids, insulin)
   - — Severe, chronic systemic disease (ASA Class 3-5)
5. Patient is physically or mentally unable to undergo a required pre-operative preparation on an outpatient basis, even with help from a home health aide, or the pre-operative preparation is so complex that outpatient preparation is not feasible.

(This report is a service to the physicians of Illinois)
6/9/89

Editorials

Mandatory Medicare assignment sidetracked—for now

Some Illinois lawmakers' latest efforts to pass mandatory Medicare assignment for physicians went down to defeat in the Senate May 26, with surprisingly little fanfare. The quiet afternoon contrasted with a similar spring day almost exactly four years prior—May 22, 1985—when physicians by the thousands traveled to Springfield from every part of the state as participants in the ISMS-coordinated initiative protesting against another legislative threat to the medical profession. That time, the issue was malpractice and the need for tort reform. And on that occasion, the medical message was loud, clear and effective. The successful rally was preceded by an intensive campaign by physicians who took advantage of every opportunity to present their views to legislators in person, by telephone or through letters.

This time, we must ruefully report that despite the importance of mandatory assignment and the necessity for physicians' forceful action, too few responded. In some areas of Illinois physicians were vocal and effective in contacting their legislators. But that didn't happen consistently throughout the state. Many legislators noted limited communications on the topic from their M.D. constituents. It was a totally different picture from our opposition, which was effectively organized and visible throughout the debate.

We were fortunate to win the mandatory assignment battle this time. But every physician can rely on a certainty: we'll be asked to fight a similar one again in the near future. We'd better be prepared to fight effectively with a broad-based campaign and the grass-root input of many physicians. Organized medicine can't afford to depend solely on the herculean efforts of a few dedicated standard-bearers.

Clean Indoor Air Act: Watch out for a "ringer"

The Illinois House took a step in the right direction when it passed a tough bill to restrict smoking in most public facilities and private work spaces, and require restaurants to assign smoke-free areas. An effective Clean Indoor Air Act would be welcome news for Illinois, and is long overdue. Now the bill moves to the Senate, where it faces serious challenge from a diluted "look alike" bill already there backed by the tobacco industry.

Let's not be fooled. The "answer" being touted by the tobacco industry is only a meek ringer for the strong, effective House bill—the one favored by ISMS and others who care about protecting public health. As physicians, our stand must be unequivocal—the legislature must not cave to pressures for laissez-faire attitudes on smoking. Every Illinois citizen needs a strong Clean Indoor Air Act. Lives depend on it. ▲

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Guest Editorial



Illustration by Myron Grossman

I'll see you in court (hopefully)!

by Alfred J.Clementi, M.D.

Many of us equate jury duty with "wasting time," or in the worst case scenario, serving for a trial that lasts longer than Ollie North's. Now we physicians, as well as some 30 other professions previously exempt from jury summons, have become part of Illinois' judicial melting pot.

I feel physicians should serve on jury duty. Jury duty is the cornerstone of our judicial system, and an inherent obligation for every law abiding citizen, regardless of profession. It's the only duty our U.S. Constitution imposes upon citizens.

Yet, some primary care physicians might complain that being cloistered by a jury can jeopardize their patients' health, if emergency medical situations arise. Surgeons have said, "What happens if you're suddenly called for jury duty, at the same time as long-scheduled surgery?

I understand and empathize with concerns for patient care. These situations can and have been worked out, by postponing and rescheduling jury duty to minimize these conflicts. In these days of growing group practices, colleagues may be found to cover emergency situations. For solo practitioners, working out alternate patient care arrangements can pose greater—but not impossible—challenges. If it's important, there may be ways to overcome the obstacles.

Many judges, greeted with the "I'm too busy to serve" excuse, ask jurors when they can serve within the year. When selecting jurors for a potentially lengthy trial, judges often ask if serving would pose a hardship.

Chicago area court systems have established one-day-one-trial systems. Fulfilling the one day wait or one trial service guarantees a citizen two years without another summons to appear.

Why should we go to all that trouble for such a small civic contribution—perhaps nothing more than keeping a seat warm in the jury waiting room? Because Illinois doctors have staked a great deal of our personal time and collective reputations on reforming Illinois' medical malpractice climate. Juries, we have said, aren't comprised of a true cross section of the public. Juries need to be educated, we have asserted.

This is our chance to get started on both, remembering the old adage that actions speak louder than words. If we doctors continually remove ourselves from the pool of prospective jurors, it decreases the quality and variety of the pool, and encourages others to remove themselves as well.

We do need educated and talented jurors. Our civil and criminal justice systems depend on it. If Illinois justice falls short of the standards we expect for fair, impartial and reasoned decision making, at least some of the blame rests with those of us who refuse to contribute our time and talents.

Our participation—no matter how slight—sends a signal that we're interested in Illinois justice. Not just from our own perspective. But in making justice work for everyone. ▲

Dr. Clementi is a board certified surgeon from Palatine, and an Illinois State Medical Society trustee.

Medicare to physicians: Diagnosis codes essential

by Karen Sandrick

PHYSICIANS are now required to report on Medicare Part B claims and itemized billing statements diagnosis codes from the *International Classification of Diseases, Ninth Revision, Clinical Modifications*—better known as ICD-9-CM. The new coding scheme sprung from provisions of the federal Medicare Catastrophic Coverage Act of 1988.

As of June 1, Illinois Medicare claims processors began the ICD-9-CM coding program in earnest. Failure to meet the new coding requirements could now affect physicians' cash flow by delaying Medicare reimbursement, with potential hold-



ups for improperly coded or non-coded claim forms while Medicare requests more specific information from physicians. During an April-June grace period to phase in the ICD-9-CM coding plan, Medicare claims processors did not return or deny claims in which codes were absent. The American Medical Association (AMA) had negotiated the grace period with Medicare.

Use of ICD-9-CM codes will not otherwise affect Medicare reimbursement to physicians or patients. Medicare will continue to base payment for the medical procedure performed on the AMA's *Current Procedure Terminology* system, fourth edition (CPT-4).

Although many physicians regularly use ICD-9-CM codes in their offices or see the codes used in hospitals, they need to be aware that the current diagnosis coding requirements differ in many cases from coding practices they have employed in the past. For example:

—Coding now must be very accurate. Medicare recommends physicians use the diagnosis code that *most specifically* fits the case. Claims processors from now on will be looking for more precise four or five digit codes, where applicable, rather than three digit codes describing a disease in general.

—Only ICD-9-CM listed codes are permitted. Unlisted codes accompanied by a narrative description of a patient's diagnosis are no longer acceptable. Physicians may, if they wish, continue to provide a narrative *in addition* to the ICD-9-CM code. There is no limit on the number of times a specific diagnosis code can be used.

(continued on page 9)

Professional Use Information

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BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be non-systemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

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Please see brief summary of prescribing information on adjacent page.

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Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If these were your patients, how would you have handled these cases?

Case #1

Presenting complaint—A 35-year-old woman found a lump in her right breast and consulted a general surgeon.

The case in brief—The surgeon examined the woman and although he felt a poorly marginated hardening, he did not feel any discernible lump. He told her to return in one month. She did so and he detected no change in her condition. However, the patient requested a biopsy. The surgeon ordered a mammogram which was done the next month. The mammogram showed evidence of a lesion but not in all views. The surgeon then telephoned the patient and told her that a biopsy was not necessary, but that she should conduct regular self-examination and followup with her gynecologist at her regular check-up. Two months later, the woman, concerned because the lump seemed to be larger, made an appointment with an associate of the surgeon's. The associate felt a lump and immediately referred the woman back to the original surgeon. He performed a modified radical mastectomy on the right breast and cancer was found. Three positive nodes were found in the axilla.

The patient underwent chemotherapy and had reconstructive breast surgery. Two years after the mastectomy, she had not had any recurrence of cancer.

The resulting claim—The patient and her husband sued for failure to detect breast cancer, alleging that the surgeon had not moved aggressively enough and had failed to order a biopsy. The main thrust of the claim was that the delay in diagnosis probably permitted a metastasis to occur.

The outcome of the claim—A settlement for $175,000 was reached.

Why problems arose with this case—Consultants said the surgeon relied too heavily upon the equivocal mammogram and should have biopsied the lump when the woman presented for her second appointment. Because the patient herself had asked for a biopsy, the fact that cancer was eventually found was a strong factor in the plaintiffs' case. The defendant contended that the mammogram had been inconclusive, that he had not previously felt an actual lump and therefore he had not violated the standard of care. The surgeon also contended that the delay would not have affected the outcome because metastasis probably already had taken place by the time of the woman's first visit. In view of the possibility of an even larger court award, the case was settled by the defendant.

Case #2

The presenting complaint—In this case, the complaint was a secondary one. A 43-year-old woman told her obstetrician/gynecologist while she was receiving care for a vaginal infection that she had noticed a change in the size and firmness of her left breast. The nipple had become discolored and the breast was painful to the touch.

The case in brief—At the time the woman mentioned the breast change, the physician made no comment and did not examine the breast. Four months later, she again complained during another visit to her physician about the enlarging breast. He did examine her at that appointment. In his own mind, the physician said later, there were several possible diagnoses—fibrocystic disease, a benign tumor, mastitis or carcinoma. He did not communicate these possibilities to the patient nor did he mention that cancer was one of them. He advised her to check the breast for any change and told her to return in one month. She telephoned his office on the day of her next scheduled appointment to report that she had not observed any further breast changes and asked if she should keep the appointment.

No one returned her call. She called again a few days later but the physician was out of town and she was given an appointment a month later. At that appointment the physician noted the swollen, tender breast. He then referred her to a surgeon who ordered a mammogram, and performed a biopsy which confirmed the presence of cancer. A radical mastectomy was performed and a mass measuring nearly four centimeters was removed. There was extensive lymph node involvement. The patient then underwent radiation therapy, chemotherapy, and a therapeutic hysterectomy. She died two years later.

The resulting claim—The woman's husband and family sued, alleging failure to diagnose and treat breast cancer.

The outcome of the claim—A jury awarded $455,000 to the plaintiffs.

Why problems arose with this case—Consultants were critical of the defendant's failure to heed the patient's initial complaint and to examine the breast at the first visit. They also were critical of his failure to order a biopsy and mammogram at the second visit when the woman again complained of the enlarging breast, and for his failure to communicate the possible seriousness of the problem to her at that time. System break-downs in the physician's office compounded the delay in diagnosis and eventual treatment.

The points these cases make—Failures to diagnose breast cancer are among the most numerous and mostly costly claims filed today. These are the typical kinds of allegations in such cases, several of which were made in the cases above:

—Failure to utilize appropriate diagnostic modalities to determine whether a breast lump is benign or not.
—Failure to aggressively follow up on suspicious breast lumps. This sometimes can be the result of system break-downs in the physician's office or between the office and the laboratory or x-ray facility.
—Failure to perform thorough physical examinations of female patients' breasts and especially when a woman says she thinks she has found a lump or has other symptoms that could indicate carcinoma.
—Failure to diagnose in a timely fashion, thus lessening a woman's chances of surviving cancer.
—Failure to obtain informed consent.

There also have been cases in which the physician has been faulted for failing to instruct the patient to perform self breast examinations.

The American Cancer Society urges all women to conduct self-examinations of their breasts every month and to obtain a baseline mammogram between ages 35-39. American Cancer Society recommends that asymptomatic women from ages 40 to 49 have a mammogram every 1-2 years and that women over 50 have one annually. Additionally, women from 20 to 40 years of age should have a professional breast examination every three years and those over 40, every year.

The American College of Obstetricians and Gynecologists (ACOG) has very similar recommendations. ACOG calls for a baseline mammogram in conjunction with a clinical physicial examination for women between the ages of 35 and 50. Women over 50 should have regular breast examinations, including mammography at least yearly.

Courts generally have upheld findings of negligence "when a physician has unreasonably failed to detect a breast abnormality upon examination and when the physician has failed to go further than a simple clinical evaluation of a suspicious breast abnormality," said authors Keith Fineberg, J.D.; J. Douglas Peters, J.D.; J. Robert Willson, M.D., and Donald A. Kroll M.D., Ph.D., in *Obstetrics/Gynecology and the Law,* published by Health Administration Press in 1984.

Clinicians agree that physicians examination of the breasts is inconclusive in diagnosing an abnormality. More accurate tools, including mammography and histopathologic examination by aspiration or biopsy are necessary adjuncts to a clinical examination of a suspicious lump. A combination of diagnostic modalities is required when results are not conclusive. All findings should be recorded in the chart.

"The courts have recognized in numerous cases that a physician faced with a patient complaint of a breast abnormality must take active steps to arrive at a conclusive and accurate diagnosis. The physician can neither assume the condition is benign after a cursory clinical examination nor prescribe a 'waiting period' for the patient," said the authors of *Obstetrics/Gynecology and the Law*. Conservative medicine may suggest a second visit within a few weeks, but aggressive followup should then be initiated if the problem appears to persist, consultants say.

To avert system failures, physicians should assure that there is a fail-safe method for recording test results of mammograms, biopsies, etc. in the chart and flagging them for action. Claims have resulted when a physician failed to see a returned test result and did not institute the proper followup procedures, especially when the patient did not call or return.

Suits for failure to diagnose breast cancer are not indefensible. Authors of *Obstetrics/Gynecology and the Law* stress that "the courts have recognized that not every incorrect diagnosis is the result of negligence." Consultants suggest that following the most current practice guidelines and complete and accurate documentation provides support for a physician's case in the event of such a claim. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *How are Swan Ganz catheter and temporary pacemaker insertions classified for insurance rating?*

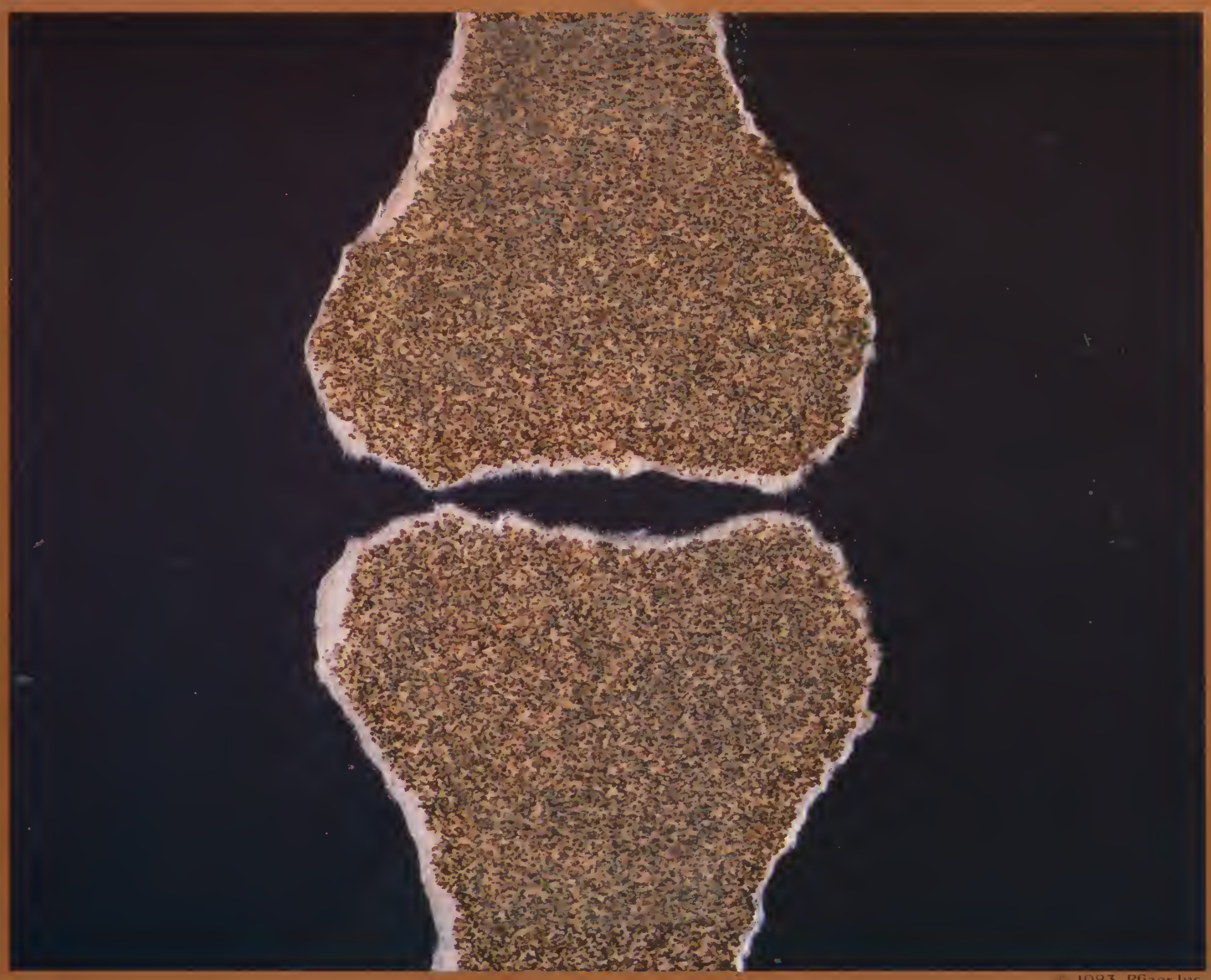
A: The two procedures have been reevaluated by Illinois State Medical Insurance Services, Inc. (ISMIS) in response to inquiries from our insureds. The similar aspects of the two procedures and the potential risks of each were considered. The conclusion of the review was to continue the present rating of Class I for Swan Ganz catheters and Class II for temporary pacemaker insertions.

Q: *When will I receive new policy documentation from ISMIE?*

A: Documentation of renewal (declaration page, certificate of insurance) will be issued automatically upon receipt of the July 1 premium payment. As a reminder, premium payments are due July 1, October 1, January 1 and April 1. If payment is not received, warning notices are sent on the fifth of the month. Cancellation for non-payment is effective on the twentieth day of the month. Policyholders submitting payment within 10 days thereafter will have their policy automatically reinstated.

Q: *Do I need to have admitting privileges at a hospital in order to obtain an insurance policy with the Exchange?*

A: All applicants and existing insureds must have admitting privileges for at least one hospital. The only exceptions to this rule are hospital-based anesthesiologists, radiologists, pathologists, and emergency medicine specialists. For any other-practice situation policyholders should contact the underwriting department. ▲



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- it's effective—proven relief of the pain and inflammation of rheumatoid arthritis and osteoarthritis[1] in millions of patients, in over 100 countries all around the world.
- it's efficient—once daily, 20-mg dose provides round-the-clock relief,[2] improves compliance and remains effective during long-term therapy.

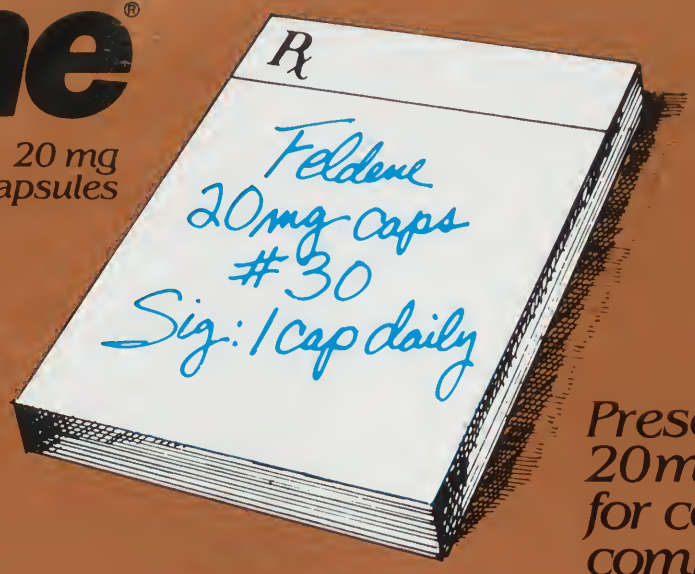
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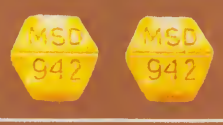
Please see FELDENE (piroxicam) brief summary on the following page.

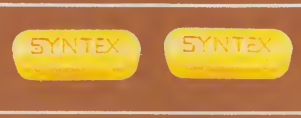
Feldene®
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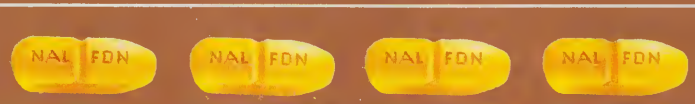


Prescribe one 20mg capsule daily for convenience and compliance

















Indicates maximum dosage for osteoarthritis and rheumatoid arthritis for the antiarthritic agents shown. Consult manufacturers' prescribing information. Source: PDR, 1989, Manufacturers' Prescribing Information.

References: 1. Siegmeth W: Serum concentrations of piroxicam in relation to its clinical effect in patients with chronic polyarthritis (trans). *Wien Med Wochenschr* 1980;130:31-35. 2. Tausch: Placebo-controlled study of piroxicam in the treatment of rheumatoid arthritis. *Am J Med* 1982;72(report):18-22

Brief Summary

FELDENE® (piroxicam) Capsules

CONTRAINDICATIONS: FELDENE (piroxicam) should not be used in patients who have previously exhibited hypersensitivity to it, or in individuals with the syndrome comprised of bronchospasm, nasal polyps and angioedema precipitated by aspirin or other nonsteroidal anti-inflammatory drugs.

WARNINGS: Peptic ulceration, perforation, and G.I. bleeding—sometimes severe, and, in some instances fatal—have been reported with patients receiving FELDENE. If FELDENE must be given to patients with a history of upper gastrointestinal tract disease, the patient should be under close supervision (see ADVERSE REACTIONS). Physicians should remain alert for ulceration and bleeding in patients treated chronically with NSAIDs even in the absence of previous GI tract symptoms.

PRECAUTIONS: Renal Effects: As with other nonsteroidal anti-inflammatory drugs, long-term administration of piroxicam to animals has resulted in renal papillary necrosis and other abnormal renal pathology. In humans, there have been reports of acute interstitial nephritis with hematuria, proteinuria, and occasionally, nephrotic syndrome.

A second form of renal toxicity has been seen in patients with prerenal conditions leading to a reduction in renal blood flow or blood volume, where the renal prostaglandins have a supportive role in the maintenance of renal perfusion. In these patients administration of an NSAID may cause a dose-dependent reduction in prostaglandin formation and may precipitate overt renal decompensation. Patients at greatest risk of this reaction are those with impaired renal function, heart failure, liver dysfunction, those taking diuretics, and the elderly.

Because of extensive renal excretion of piroxicam and its biotransformation products (less than 5% of the daily dose excreted unchanged), lower doses of piroxicam should be anticipated in patients with impaired renal function, and they should be carefully monitored.

Although other nonsteroidal anti-inflammatory drugs do not have the same direct effect on platelets that aspirin does, all drugs inhibiting prostaglandin biosynthesis do interfere with platelet function to some degree.

Because of reports of adverse eye findings with nonsteroidal anti-inflammatory agents, it is recommended that patients who develop visual complaints during treatment with FELDENE have ophthalmic evaluation.

As with other nonsteroidal anti-inflammatory drugs, borderline elevations of one or more liver tests may occur in up to 15% of patients. A patient with symptoms and/or signs suggesting liver dysfunction, or in whom abnormal liver tests have occurred, should be evaluated for evidence of the development of more severe hepatic reaction while on therapy with FELDENE.

Severe hepatic reactions, including jaundice and cases of fatal hepatitis, have been reported with FELDENE. Although such reactions are rare, if abnormal liver tests persist or worsen, if clinical signs and symptoms consistent with liver disease develop, or if systemic manifestations occur (e.g., eosinophilia, rash, etc.), FELDENE should be discontinued. (See also ADVERSE REACTIONS.)

Although at the recommended dose of 20 mg day of FELDENE increased fecal blood loss due to gastrointestinal irritation did not occur, in about 4% of the patients treated with FELDENE alone or concomitantly with aspirin, reductions in hemoglobin and hematocrit values were observed.

Peripheral edema has been observed in approximately 2% of the patients treated with FELDENE. Therefore, FELDENE should be used with caution in patients with heart failure, hypertension or other conditions predisposing to fluid retention.

A combination of dermafological and/or allergic signs and symptoms suggestive of serum sickness have occasionally occurred in conjunction with the use of FELDENE. These include arthralgias, pruritus, fever, fatigue, and rash including vesiculo bullous reactions and exfoliative dermatitis.

DRUG INTERACTIONS: Interactions with coumarin-type anticoagulants have been reported with FELDENE since marketing. Therefore, physicians should closely monitor patients for a change in dosage requirements when administering FELDENE to patients on coumarin-type anticoagulants and other highly protein-bound drugs.

Plasma levels of piroxicam are depressed to approximately 80% of their normal values when FELDENE is administered in conjunction with aspirin (3900 mg/day), but concomitant administration of antacids has no effect on piroxicam plasma levels.

Nonsteroidal anti-inflammatory agents, including FELDENE, have been reported to increase steady state plasma lithium levels. It is recommended that plasma lithium levels be monitored when initiating, adjusting and discontinuing FELDENE.

Carcinogenesis, Chronic Animal Toxicity and Impairment of Fertility: Subacute and chronic toxicity studies have been carried out in rats, mice dogs, and monkeys.

The pathology most often seen was that characteristically associated with the animal toxicology of anti-inflammatory agents: renal papillary necrosis (see PRECAUTIONS) and gastrointestinal lesions.

In classical studies in laboratory animals, piroxicam did not show any teratogenic potential.

Reproductive studies revealed no impairment of fertility in animals.

Pregnancy and Nursing Mothers: Like other drugs which inhibit the synthesis and release of prostaglandins, piroxicam administration continued late into pregnancy increased the incidence of dystocia and delayed parturition in animals. Gastrointestinal tract toxicity was increased in pregnant females in the last trimester of pregnancy compared to non-pregnant females or females in earlier trimesters of pregnancy.

FELDENE is not recommended for use in nursing mothers or in pregnant women because of the animal findings and since safety for such use has not been established in humans.

Use in Children: Dosage recommendations and indications for use in children have not been established.

ADVERSE REACTIONS: Gastrointestinal symptoms are the most prominent side effects, occurring in approximately 20% of the patients, which in most instances did not interfere with the course of therapy. Of the patients experiencing gastrointestinal side effects, approximately 5% discontinued therapy with an overall incidence of peptic ulceration of about 1%.

Adverse reactions are listed below by body system for all patients in clinical trials with FELDENE (piroxicam) at doses of 20 mg day.

Incidence Greater Than 1%: The following adverse reactions occurred more frequently than 1 in 100.

Gastrointestinal: stomatitis, anorexia, epigastric distress,* nausea,* constipation, abdominal discomfort, flatulence, diarrhea, abdominal pain, indigestion.

Hematological: decreases in hemoglobin* and hematocrit* (see PRECAUTIONS), anemia, leucopenia, eosinophilia.

Dermatologic: pruritus, rash.

Central Nervous System: dizziness, somnolence, vertigo.

Urogenital: BUN and creatinine elevations (see PRECAUTIONS).

Body as a Whole: headache, malaise.

Special Senses: tinnitus.

Cardiovascular Respiratory: edema (see PRECAUTIONS).

* Reactions occurring in 3% to 9% of patients treated with FELDENE. Reactions occurring in 1% to 3% of patients are unmarked.

Incidence Less Than 1% (Causal Relationship Probable): The following adverse reactions occurred less frequently than 1 in 100. The probability exists that there is a causal relationship between FELDENE and these reactions.

Gastrointestinal: liver function abnormalities, jaundice, hepatitis (see PRECAUTIONS), vomiting, hematemesis, melena, gastrointestinal bleeding, perforation and ulceration (see WARNINGS), dry mouth.

Hematological: thrombocytopenia, petechial rash, ecchymosis, bone marrow depression including aplastic anemia, epistaxis.

Dermatologic: sweating, erythema, bruising, desquamation, exfoliative dermatitis, erythema multiforme, toxic epidermal necrolysis, Stevens-Johnson syndrome, vesiculo bullous reactions, photoallergic skin reactions.

Central Nervous System: depression, insomnia, nervousness.

Urogenital: hematuria, proteinuria, interstitial nephritis, renal failure, hyperkalemia, glomerulitis, papillary necrosis, nephrotic syndrome (see PRECAUTIONS).

Body as a Whole: pain (colic), fever, flu-like syndrome (see PRECAUTIONS).

Special Senses: swollen eyes, blurred vision, eye irritations.

Cardiovascular Respiratory: hypertension, worsening of congestive heart failure (see PRECAUTIONS), exacerbation of angina.

Metabolic: hypoglycemia, hyperglycemia, weight increase, weight decrease.

Hypersensitivity: anaphylaxis, bronchospasm, urticaria, angioedema, vasculitis, "serum sickness" (see PRECAUTIONS).

Incidence Less Than 1% (Causal Relationship Unknown): Other adverse reactions were reported with a frequency of less than 1 in 100, but a causal relationship between FELDENE and the reaction could not be determined.

Gastrointestinal: pancreatitis.

Dermatologic: onycholysis, loss of hair.

Central Nervous System: akathisia, hallucinations, mood alterations, dream abnormalities, mental confusion, paresthesias.

Urogenital System: dysuria.

Body as a Whole: weakness.

Cardiovascular Respiratory: palpitations, dyspnea.

Hypersensitivity: positive ANA.

Special Senses: transient hearing loss.

Hematological: hemolytic anemia.

OVERDOSAGE: In the event treatment for overdosage is required, the long plasma half-life of piroxicam should be considered. The absence of experience with acute overdosage precludes characterization of sequelae and recommendations of specific antidotal efficacy at this time. It is reasonable to assume that the standard measures of gastric evacuation and general supportive therapy would apply. In addition to supportive measures, the use of activated charcoal may effectively reduce the absorption and reabsorption of piroxicam. Experiments in dogs have demonstrated that the use of multiple-dose treatments with activated charcoal could reduce the half-life of piroxicam elimination from 27 hours without charcoal to 11 hours and reduce the systemic bioavailability of piroxicam by as much as 37% when activated charcoal is given as late as 6 hours after administration of piroxicam.

ADMINISTRATION AND DOSAGE: Rheumatoid Arthritis, Osteoarthritis: It is recommended that FELDENE therapy be initiated and maintained at a single daily dose of 20 mg. If desired, the daily dose may be divided.

Dosage recommendations and indications for use in children have not been established.

More detailed professional information available on request.

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Ethics in medical education: students, physicians tackle issues

by Janice Rosenberg

This is the second of two articles discussing the increasing emphasis on health care ethics and accompanying dilemmas for physicians in a changing society. This segment focuses on how medical schools are integrating ethics into the training of Illinois' future physicians.

IN MEDICAL schools around Illinois, ethics is as common a part of the curriculum as biochemistry and anatomy. Just fifteen years ago, however, courses in ethics were rare. "Back then the existing examples were notable as exceptions," says George Agich, Ph.D., a professor in the medical humanities department at Southern Illinois University Medical School in Springfield. "The surge began in the mid-seventies."

With the rapid growth of technology, for the first time physicians faced problems of allocating lifesaving technologies. For example, the equipment available for renal dialysis could not keep up with patient demand. "That," says Agich, "put doctors in the position of having to choose among patients who would all clearly be helped, and that posed a question. Could the doctor ever make that choice?"

Raising new questions on life and death

Improved technology raised new questions about issues that had once been easily understood. When does life begin? How is death defined? With intricate life support systems available and organ transplants an increasingly common possibility, there were no longer clear cut answers.

For their part, medical students complained of feeling dehumanized. They spent more and more time studying basic sciences and technical aspects of medicine. Meanwhile they were receiving no training to counteract the dehumanization process or help them address ethical questions raised by new technology. Clearly, something had to be done.

Today, medical ethics is taught at all Illinois medical schools. According to Kenneth Vaux, Ph.D., professor of medical ethics at the University of Illinois Medical School in Chicago, course content derives from several sources including basic philosophical concepts. "Philosophy is the discipline of our society that reflects on the meaning and value of things," Vaux says. "Medical ethics is philosophy practically applied to medical questions."

The Medical Environment

A periodic observation on issues and trends affecting modern medical practice, and the challenges they present.

Religious ethics serve as another source. "There is a rich tradition of ethical thought in medicine," says Vaux, "that comes out of the world's great religions." Still another source is the medical profession's own ancient tradition of ethics as recorded in the Oath of Hippocrates, the Code of Maimonides, and the Nuremburg Code.

Medical schools' approaches vary

A sampling of Illinois medical schools shows a variety of approaches to the teaching of ethics. Southern Illinois University Medical School created its medical humanities department in 1976. Third year students receive in-depth ethical training as part of their clinical clerkships. A basic course called "Physician-Patient Relationship" covers legal issues such as informed consent, malpractice, and confidentiality. Students also take mini-courses in medical ethics taught by department members with religious, philosophical, or legal backgrounds. In the fourth year a two-week full time research elective is available to highly motivated students.

At the University of Illinois Medical School in Chicago, students take a short second year course called "Ethics, Law, and Medicine." More concentrated work in ethics begins with third year clinical studies. Teams, including specialists in ethics and humanities and medical clinicians, teach courses relevant to individual services. On occasion, medical students take full time electives in ethics or humanities.

Vaux's U. of I. department also trains the house staff. Conferences are held with residents. "We do rounds on each of the services," he says, "and give courses tailor-made to each of the residencies."

Integrating ethics into curriculum

Northwestern University Medical School began its ethics program in 1977, after more than one hundred medical students signed a letter to the dean asking for courses in ethics. Discussions in the first two years cover a wide range of topics.

In the second two years, students attend clerkship seminars. "We draw the students out on the kinds of issues they're actually running into," says James Bresnahan, Ph.D., co-director of the program.

In these seminars, students learn to talk about their values. "People have values," says Bresnahan, "the problem is getting them out in the open so that we can talk [about] them." Physicians must try to understand patients' values as well as those of medical colleagues, noted Bresnahan. Conflicts must be resolved, not by one person taking charge, but by a cooperative effort to agree on a course of action that will be in the best interest of the patient. "Our aim is to sensitize students to this and to help them become more facile in discussing them," he said.

The department of medical humanities at Loyola University's Stritch School of Medicine runs a four year required program in ethics. The program, begun in 1981, is directed by philosopher David Thomasma, Ph.D.

According to Assistant Director Patricia Marshall, Ph.D., the main objective of the program is to encourage students to think reflectively about patient care and ethical crises that arise. "There is no right or wrong answer in medical ethics," she says. "What's really important is to become reflective about your own values and examine them very systematically. That's what we encourage here."

In the first and second years Stritch students are introduced to a specific method of ethical reasoning, and work at applying that reasoning to cases. Third year students are required to write ethical case analyses based on their own clinical work. In the fourth year, students choose from thirty electives taught by clinicians, historians, philosophers, lawyers, and other professionals.

Physician ethicists as teachers and counselors

While physicians do participate in medical school ethics programs, faculty members in most ethics and humanities departments are not M.D.s. The majority hold Ph.D. degrees in philosophy.

The center for clinical medical ethics at the University of Chicago Medical School is an exception to this rule. There, Mark Siegler, M.D., has directed training in medical ethics for more than ten years. Dr. Siegler sees clinical medical ethics as a branch of bioethics and has developed it to look at specific patient care decisions with an eye toward improving them.

The aim of the four year medical school curriculum is to help students develop the ability to identify problems and to respond to them. In the first three years, students meet in small groups with faculty clinicians and physician ethicists to discuss cases. In the fourth year about twenty five percent of the students take an elective reading course in ethics or participate in the ethics consultation service.

The center also trains physician ethicists through a junior fellowship program. "Our mission," says Laura Lane, M.D., director of programs, "is to take physicians just out of clinical training and develop their interests in ethics. We give them methodological skills and philosophical training in the history of ethical questions. And we give them individual guidance so that they can develop academic careers, set up curricular programs, and spread the word on clinical ethics to other institutions."

In the years to come, ethical training for medical students and the participation of philosophers and physican ethicists in health care decision making will continue to exercise a strong influence on the practice of medicine. ▲

Medical students discuss lessons they learn

Today's medical students agree wholeheartedly on the value of studying ethics. "When you're trying to absorb so much basic science it's easy to forget about the ethical and human dimensions in our future careers," said John Butter, a second year student at Northwestern University Medical School. "That's why I think it's very important to have ethics as part of the curriculum." Butter appreciated his ethics classes as opportunities for self-expression. "I was actually asked what I thought about an issue," he said. "That's something that doesn't usually happen during the first two years of medical education."

Required courses at Loyola University's Stritch School of Medicine allowed Joan Surdukowski, a second year student, to begin building a framework for ethical decision making. "We're going to be faced with many ethical dilemmas as physicians," she said. "I think these courses will really be helpful when I get into the clinical years."

Students who are further along in their training have already benefited from their classroom case analyses. "In class we learned that there isn't a right or wrong answer to any question," said Nancy McCarthy, a third year student at Northwestern. "When I was on a medical service we discussed how far you should go in treating a DNR patient. Opinions varied."

During an elective rotation at a hospice, fourth year Southern Illinois University medical student Mary Bretscher found herself deeply troubled by the question of whether or not to continue nutrition and hydration to patients in coma. "My gut reaction at the beginning," she said, "was 'How could I ever withhold water from my loved ones?' It was an emotional issue." Bretscher did research in both medical and ethical journals, applying methods of analysis learned in ethics courses taught by the school's medical humanities department. After reading and studying, she changed her mind. "There isn't a right or wrong answer to these questions," she said. "I got a chance to think about this issue in depth, and I know that will benefit me once I get into practice."

Third year SIU student Kathy Lake-Smith discovered that in clinical settings, ethical issues are not as clear cut as they are in the classroom. Lake-Smith disagreed ethically with a physician who delayed telling a patient that she had pancreatic cancer. "He wasn't telling her about it in the amount of time that I felt was reasonable," said Lake-Smith. "I couldn't go in and be the one to tell her, but it was bothering me."

Students offer a number of explanations for the recent trend toward including ethical training in medical school curriculums. "One of the things emphasized here is patient autonomy," said Lake-Smith. "Doctors are not parents or godlike figures. They have to offer patients alternatives."

Third year SIU student Kevin Matteson agreed. "They aren't off by themselves any more. Everybody is looking at them. Decisions have to be more formally done and we have to learn how to do that."

"Because of medical technology we're presented with more varied and frequent ethical dilemmas," concluded Bretscher. "You can't practice medicine and avoid ethical dilemmas. You have to be informed about the issues and aware of the different arguments so that you can help families and patients make decisions." ▲

Rockford "May Day Clinic" attracts noted medical experts as informative speakers

by Denise Showers

TOP PHYSICIANS at the 50th annual Theodor Lang May Day Clinic in Rockford, May 5 and 6, waxed philosophical and ethical as often as instructive, as physicians given a podium outside the classroom are wont to do.

The clinic, sponsored by the St. Anthony Medical Center and cosponsored by the University of Illinois College of Medicine at Rockford, was held at the Clock Tower Resort. The annual Rockford tradition is coordinated by Paul Maxwell, M.D., Rockford cardiologist and director of St. Anthony's continuing medical education program.



Paul A. Maxwell, Jr., M.D., coordinator of the May Day Clinic.

Artificial heart pioneer notes new developments

Keynote speaker Robert K. Jarvik, M.D., gained international recognition for the design and development of the JARVIK-3, -5 and -7 artificial hearts and the electrohydraulic energy converter. He is assistant research professor of surgery at the University of Utah College of Medicine.

Dr. Jarvik spoke on the current status of, and new developments for the artificial heart.

"What we need is a complete overhaul in philosophy and a major simplification of how the [artificial heart] system is approached," said Dr. Jarvik.

Currently the artificial heart is used exclusively as a bridge to a living heart transplant. Dr. Jarvik outlined steps necessary to make permanent use feasible.

"The artificial heart will probably never be used permanently until we can afford true mobility and an excellent quality of life (for the patient)," said Dr. Jarvik.

He cited the amount of medical follow-up, post-management, mechanical maintenance, risk of infection and general expense as current barriers to permanent use.

"If we maintain some components outside the body we allow for some emergency procedures and [mechanical] maintenance," he said.

Few legal or ethical barriers remain with respect to the permanent artificial heart, according to Dr. Jarvik. But the post-operative quality of life presents the most difficult barrier to its use. Research and development poses another problem.

"The amount of money spent on this research is trivial," said Dr. Jarvik, adding that monies for AIDS research are huge. "The fact is that fewer than 50,000 deaths to date are attributed to the AIDS virus, while we lose 500,000 heart patients every year to heart disease.

"We can do better," Dr. Jarvik concluded.



Photos by Jon McGinty

Robert K. Jarvik, M.D., designer of artificial hearts.

Cardiac surgical innovator sees societal problem

Michael Ellis DeBakey, M.D., who developed the Dacron and Dacron velour artificial grafts for replacing diseased arteries in 1950-1953, also addressed the May Day Clinic. He sewed the first Dacron graft on his wife's sewing machine.

Dr. DeBakey's work in the office of the Surgeon General led to the development of mobile army surgical hospitals (MASH units), and in 1932, while still in medical school, he invented the roller pump, which became a major component of the heart-lung machine.

Dr. DeBakey now serves as the chancellor of Baylor College of Medicine and director of the DeBakey Heart Center in Houston, Texas.

Dr. DeBakey said the U.S. has "one of the greatest medical systems in the world. Unfortunately, that medical care is not available to every American."

He warned, however, that nationalized medicine is not a good option to solve that problem. He cited rationing problems within England's government-controlled health care system.

"There's a five-year waiting list for hip replacement and a three-year waiting list for coronary bypass surgery in England," said Dr. DeBakey. "Of course by then the patients are dead. Nationalized health care erodes the clinical freedom we have. And in the U.S., if you don't like the health care you're getting, you can go somewhere else." Patients in England, he said, must seek medical attention within assigned districts.

"Still," Dr. DeBakey said, "we've got to approach this problem as a society. We've got to decide whether or not we're willing to pay for the highest-quality health care for *all* our people."



Michael E. DeBakey, M.D., cardiovascular surgeon, addresses the luncheon audience.

Noted gastroenterologist advises "parental" role for physicians

Internationally-respected gastroenterologist Howard M. Spiro, M.D., addressed a general session at the clinic regarding "Non-Ulcer Dyspepsia." Dr. Spiro is professor of medicine and director of the program for humanities in medicine at Yale.

"It's not what you eat," Dr. Spiro asserted, "it's what's eating you. In general, we may pay too much attention to what we put into our stomachs. I'd worry more about the problem of malnutrition than about what middle-class Americans are eating."

At a press conference Dr. Spiro said we are "a nation of valetudinarians . . . someone who is continually and perpetually worried about his or her health."

Dr. Spiro said the new "wonder drugs," currently used to treat peptic ulcers, "really do change the way people treat their stomachs."

"In the old days, doctors would worry about psyche, family problems and a lot of other things. It's easy in 1989 to take care of ulcers and whether it's a blessing or not is in question."

During a gastrointestinal workshop Dr. Spiro said that patients are entitled to have as much control over their treatment as possible. He said physicians need to take a "parental rather than a paternal approach to our patients." The difference, he said, is that "one advises; the other one tells."

A "radical" approach to health care reform

Oregon State Senate President John Kitzhaber, M.D., a practicing emergency physician in Roseberg, Oregon, spoke to a general session at the May Day Clinic on "Developing an Equitable Health Care Policy with Limited Resources."

A bill sponsored by Dr. Kitzhaber and others, currently before the Oregon state assembly, has been termed "radical" in the near-total health care provision reforms it calls for. Full details of the Kitzhaber plan will be featured in an upcoming *Illinois Medicine.* ▲

Obituaries

***Axelrod**
David Axelrod, M.D., of Chicago, died January 27, 1989, at the age of 70. Dr. Axelrod was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

***Kinney**
Edward J. Kinney, M.D., of Alton, died February 12, 1989, at the age of 77. Dr. Kinney was a 1943 graduate of Loyola University Stritch School of Medicine, Maywood.

***Schlich**
Ross Schlich, M.D., of Springfield, died January 20, 1989, at the age of 72. Dr. Schlich was a 1948 graduate of St. Louis University School of Medicine, St. Louis, Missouri.

****Smullen**
Willard C. Smullen, M.D., of Decatur, died January 30, 1989, at the age of 73. Dr. Smullen was a 1939 graduate of Indiana University School of Medicine, Indianapolis, Indiana.

****Szanto**
Paul B. Szanto, M.D., of Chicago, died February 6, 1989, at the age of 84. Dr. Szanto was a 1929 graduate of Universitaet Wien, Medizinische Fakultaet, Wien, Austria.

***Van Bergen**
William S. Van Bergen, M.D., of Effingham, died February 3, 1989, at the age of 54. Dr. Van Bergen was a 1959 graduate of Northwestern University Medical School, Chicago.

****Vandermyde**
Isaac Vandermyde, M.D., of Morrison, died January 25, 1989, at the age of 87. Dr. Vandermyde was a 1928 graduate of Rush Medical College, Chicago.

**Indicates ISMS Member*
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New Medicare regulations set for July

July symbolizes independence for most Americans, but physicians may rather equate it with the implementation date of several new Medicare regulations.

Documentation for referring MDs

One regulation requires physicians who treat referred patients to note on the Medicare claim form the name and provider identification number of the referring physician.

Group billing identification number

Under another new provision effective July 1, all groups submitting Part B Medicare claims under a common billing number will be required to include an assigned six-character provider number on claim forms for each physician in the group who provides services reported on that claim form.

The identifiers for group billing purposes do not affect the separate individual identifiers used by physicians for billing individual services, and they have no effect on reimbursement levels.

Medicare has begun sending the newly assigned provider numbers and specialized billing instructions to those affected.

Preadmission certification for selected procedures

Also beginning July 1, physicians scheduling certain "elective" surgical procedures for their Medicare patients are required to include a precertification number on the Medicare Part B claim form. Since April 1, physicians have been required to obtain this preadmission certification number for affected procedures from the Crescent Counties Foundation for Medical Care, the PRO for Illinois, according to Romaine Ford, Medicare B professional relations administrator.

HCFA is now requiring surgeons who perform the designated procedures to also include the preadmission certification number on Medicare Part B claim forms. A June 5 Medicare news bulletin advised physicians that the precertification number must appear for claims dated July 1 and thereafter. Physicians were also advised on where to place the number on the form, said Ford.

As previously explained in the April 28 *Illinois Medicine*, the ten "elective" procedures subject to Medicare's new preadmission certification requirement include: cholecystectomy; carotid endarterectomy; major joint replacement; coronary artery bypass with graft; percutaneous transluminal coronary angioplasty; laminectomy; complex peripheral revascularization; hysterectomy; prostatectomy; and cataract. ▲

Medicare codes

(continued from page 5)

—Codes describing symptoms and signs, rather than diagnosis, are acceptable, as long as the physician documents the "level of certainty," which ICD-9-CM lays out to help quantify symptoms, signs and ill-defined conditions. When "ruling out" a suspected diagnosis, physicians should use symptom, abnormal test result and signs codes, to the highest "level of certainty" they are able.

—Up to four diagnoses can be coded on a claim form. Physicians should list first the diagnosis, condition or symptom code chiefly responsible for the medical services provided—the one that best describes the reason for the patient's visit or encounter. In concurrent care cases, physicians should code *only* the condition they personally treat.

—Anesthesiologists and asssistant surgeons should use diagnosis codes specifying the reason for performing surgery.

The catastrophic coverage law outlines sanctions for physicians who fail to comply with the coding mandate. Civil monetary fines—up to $200 per incident—can be levied against physicians not including ICD-9-CM codes on Medicare patient bills or claims forms submitted directly to the government.

During the start up year, however, the Health Care Finance Administration, Medicare's administrative arm, has assured the AMA that compliance efforts will center on education and instruction rather than penalties. ISMS' Committee on Third Party Payment Processes is monitoring the program. Physicians having specific questions or problems should contact the medical society's health care finance division.

Illinois' Medicare carrier (Blue Cross/Blue Shield) is holding seminars to inform physicians of the coding requirements. Its department of professional relations will also be answering physician coding questions at (312) 938-7923.

The three volume set of ICD-9-CM codes contains instructions on using the coding system's abbreviations, symbols and proper sequencing of codes. The volumes may be purchased from the superintendent of documents, U.S. Government Printing Office. Send orders to ICD-9-CM third edition, P.O. Box 360121, Pittsburgh, PA. 15250-6121. The purchase price of $43 covers the basic coding books plus subsequent addenda through 1991. ▲

Hospital/physician computer links: new "bonding" tool

by Carroll Thomas

LOYAL DOCTORS are worth more than their weight in gold to Illinois hospitals who, like their counterparts elsewhere, are being forced to compete as never before. Thanks to shrinking demand for inpatient hospital-based services, physicians who hold the key to maintaining admissions are being courted furiously, and not just with prime parking spaces and conveniently located office suites.

A handful of hospitals have taken the battle high-tech, offering to provide their medical staff members with computer systems designed to make professional life easier. The hope is that—by offering such perks as quicker access to test results, current patient status, demographic and financial data on patients, and state-of-the-art practice management programs—these hospitals will induce "computer-linked" physicians to favor them with admissions and outpatient services.

Apparently, it works. An early entrant in this electronic sweepstakes, Little Company of Mary Hospital in Evergreen Park, found that its computer link was worth an additional $4 million in revenue, based on a 1987 study. Doctors connected to the hospital by computer generated more revenue than non-linked physicians, a whopping 20 percent more in 1985 and 1986 in the case of family practitioners. Since embarking on its computer campaign in 1984, Little Company of Mary has installed systems in nearly 70 physicians' offices.

"If our hospital is able to provide lab results 12 hours quicker than somebody else, we'd hope that would be recognized by our physicians," says Dennis Reilly, director of information systems at Little Company of Mary.

Lutheran General Hospital in the Chicago suburb of Park Ridge began installing a similar system three years ago, and now has 28 practices on line, says Mari Partipilo, a resource analyst in the hospital's information systems department. Franciscan Sisters Health Care Corp., a hospital chain with facilities in Danville, Joliet, Elgin, Chicago and Waukegan, is in the process of linking up with its doctors. The corporation bought 100 systems to be placed in doctors' offices, and already has installed 52, according to Robert Kelsey, executive vice president at the chain's United Samaritans Medical Center in Danville. Like Little Company of Mary, those hospitals bought the Annson-Link system marketed by Annson Systems Division of Baxter Healthcare Corp., based in Northbrook.

Meanwhile, Louis A. Weiss Memorial Hospital in Chicago is shopping for an electronic link to offer to its medical staff. And MEDIC Computer Systems, a Raleigh, N.C.-based company with offices in Rolling Meadows, plans to install its physician link at an Illinois hospital soon. Since MEDIC's client hospital is still in the planning stage, the company will not disclose the hospital's identity.

"Bonding" is the game

Competition is at the heart of this movement. In multi-hospital markets, most physicians maintain privileges at more than one facility. Since DRGs, HMOs, reduced inpatient days and other cost-cutters came along, operating margins at some hospitals are so tight that just a few additional patient days per month can mean the difference between profit and loss. Hence, hospitals are anxious to lock in the loyalty of their physicians.

"All the literature you see says that a computer link is the number one physician bonding tool," says Karen Fulford, vice president of physician relations at Weiss Memorial Hospital. "It's kind of a sure thing if you are the most convenient hospital."

Fulford points out that, if a hospital provides support staff to help the doctor and his employees adapt to the system, "the tie is very strong, since they'll lean on you for a lot of things."

Additionally, according to Fulford, an integrated computer system provides flexibility and ease for physicians, who can call up lab, x-ray or EKG results from a home or office computer, pre-admit patients, pre-register patients for outpatient procedures or tests, and get information needed for billing directly from hospital records.

Proponents say patients benefit, too, since doctors can keep closer tabs on them, and relieve some of the anxiety patients have about entering the hospital by providing pertinent preadmission information.

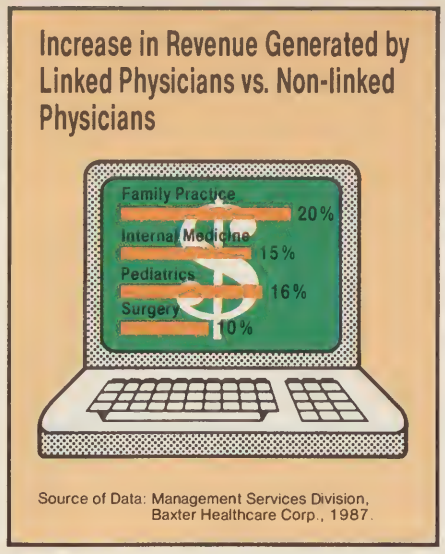
The principal advantage is that it eases the process for a physician to admit, care for, and follow patients by being linked to the hospital.

"The principal advantage is that it eases the process for a physician to admit, care for, and follow patients by being linked to the hospital," says Kelsey, of Danville's United Samaritans Health Center, which so far has 19 "linked" practices.

How links work

The concept behind hospital-physician computer links sounds simple: A doctor's office is outfitted with a mini- or micro-computer and a modem, a device that allows the computer to tap into the hospital mainframe via telephone lines. To preserve security, the physician or his assistant must use a special password or code to receive data. Some systems require the hospital's mainframe to dial back the doctor's computer to make sure the right practitioner is getting sensitive patient information.

In practice, things are a bit more complicated than that. Just what kind of information physicians can get depends on what data the hospital stores in its mainframe, how much of it hospital executives are willing or able to share, and how fast the data are fed into the mainframe. For example, if a hospital lab is equipped to zap test results into the mainframe instantaneously, a doctor theoretically could monitor bloodwork on his hospitalized patient at designated intervals 24 hours a day.



Besides electronic access to the hospital's data, physicians get an automated management system for their own offices—one that is compatible with the hospital's software. In seconds, a doctor's staff can obtain patient information needed for billing directly from the hospital computer. The data can then be used to generate insurance forms, bills, and keep a running account of the practice's receivables. The office management systems can also keep track of individual patients' financial records, provide up-to-date financial statements on the overall practice, and even file claims electronically to major insurers.

Hospitals are reluctant to reveal the financial arrangements they make with doctors who accept their computer links. That's because hospitals don't offer the same deal to every doctor or group on staff. "It depends on the physician's relationship to the hospital. Some are required to make a fairly substantial commitment, others are not," says Little Company of Mary's Reilly.

Kelsey says that United Samaritans' cost for each installation is about $18,000—$6,000 each for software and hardware, and $2,000 for support staff and a maintenance contract over three years. Doctors are offered the option of leasing both hardware and software, or buying hardware and leasing the software. However, specific agreements with physicians may vary, as United Samaritans assesses the value of each installation based on the number of admissions or potential admissions it can generate.

"Some hospitals have given them away. Others give the software and have physicians buy the hardware. Others are providing loans or leases, or giving out the systems with a requirement that doctors pay later. I've even heard of giving interest-free financing over a five-year period," says Susan Van Buren of MEDIC Computer Systems.

"We recommend that doctors have some financial investment. Otherwise, they may not use the systems," she adds.

"In a highly competitive market, hospitals will be as accommodating as possible," says George Roy, marketing director for Baxter's Annson Systems Division.

How doctors use links

At Little Company of Mary Hospital, doctors and their assistants can use office-based computers to obtain lab results, make consult requests, obtain demographic and insurance information on patients, request surgical reservations, obtain discharge and admit dates, and refer to data banks that provide information on drug interactions and PRO screening requirements, all without picking up the phone, wasting time on hold, or waiting for callbacks from hospital personnel.

Lutheran General allows its doctors to obtain a current census report on their patients, and both consulting and primary care physicians can obtain clinical or demographic information on specific patients. Practitioners also can review testing and pharmacy orders. Doctors linked to Lutheran General's system soon will enjoy a welcome new feature, says Partipilo. They'll have access to the ICD-9 codes required for Medicare billing, and be assured that the hospital diagnosis matches the code.

But how much being "linked" to the hospital influences doctors' admitting decisions apparently depends in part on specialty. That 1987 study showing added revenue flowing from Little Company of Mary's link suggested as much. While linked family practice specialists generated 20 percent more revenue than non-linked FPs, the figure for pediatricians was 16 percent, for internists 15 percent, and for surgeons, just 10 percent.

"I wouldn't say it's a big factor for me," says Lawrence Stone, M.D., a Park Ridge internist specializing in oncology, and one of the first doctors to accept Lutheran General's link. Dr. Stone, who has privileges at three hospitals, is more interested in preserving referral patterns with doctors at those facilities than taking advantage of the hospital link.

Because of delays in the hospital's data entry systems, Dr. Stone says he often can get lab and x-ray reports he's ordered quicker by picking up the phone. Computer access is more useful when a patient walks into the office and announces he's recently had tests at the hospital. If the results are still in Lutheran General's system, Dr. Stone can get them while the patient waits.

Primary care doctors seem more likely to be influenced by a computer link. Assuming hospitals offer equal quality care in the specific services his patients need, and the patients themselves have no preference, family practice specialist Lee B. Sacks, M.D., says he'd strongly prefer admitting to a "linked" hospital. Lutheran General's link is "definitely a time-saver" for him and his staff, says Dr. Sacks.

"We can look up outpatient test results and reports on emergency room visits and print out a copy right here in the office," says Dr. Sacks. "I can check out my patients without waiting for someone to look them up, or getting the wrong patient, or fouling up."

Dr. Sacks says he believes the link helps him provide better patient care. "If I can get information on my patient this afternoon, instead of waiting until morning, the patient will be 12 hours ahead," he says.

Doctors' use of the link at United Samaritans Health Center in Dan-

(continued on page 11)

Links

(continued from page 10)

ville has so far been somewhat limited. That's because United Samaritans is still in the process of merging Danville's two hospitals into one, and installation of the link was only begun last year. In fact, the Franciscan Sisters hospitals across the state are in various stages of implementing it, says Kelsey.

Mehdi Adeli, M.D., a Danville orthopedic surgeon, says he's barely used the link, except to obtain demographic information used in patient billing and filing insurance claims. But he looks forward to the added convenience of pre-admitting, making surgical suite reservations, and obtaining test results electronically. "I believe this will lead to improved patient care," he says. "The computer will take care of lots of time-consuming tasks, and do it without us going back and forth with the hospital."

Wave of the future

Hospital-physician computer links, relatively rare today, seem destined only to grow. Dr. Stone, who serves on a physician advisory committee for Annson, says current uses are "embryonic" compared to the capabilities that computer technology offers. Annson, for example, has an enhancement that allows physician-to-physician communications. With it, primary care doctors and consultants can exchange patient data at the push of a button.

Eventually, physicians may have essentially paperless offices, with patients' medical records stored in computers, predicts Dr. Stone. "Then I'll be able to download an x-ray report from the hospital right into the chart," he says.



Lawrence A. Stone, M.D., and office manager Rochel Catler retrieving patient information from Lutheran General's mainframe.

Meanwhile, Annson's Roy predicts more hospitals will invest in links as they update their internal information systems. Many hospitals automated various departments piecemeal, installing one type of system in the lab, another in accounting, and so on. Now they're realizing that an integrated information system, shared by all departments, is an important competitive tool.

Instead of trying to lure patients with "soft marketing," such as televised ads touting their caring service, visionary hospital executives have "finally realized that it's the doctor who makes the choice," says Roy. "Now they're ready to go to the source—the doctor—and influence that admission." ▲

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THE POWER IS ON

Physician/sculptor blends art and career

by Vicki Gerson



Photo by The Photo Partners, Inc.

Herman Lander, M.D., shown with his artwork.

THREE NIGHTS a week, Herman Lander, M.D., does not read medical journals or ponder clinical problems he's encountered during the course of his pediatric practice on Chicago's north side. Instead, he spends time in his art studio or in class at the Contemporary Art Workshop creating sculptures ranging from the serious to the whimsical.

Dr. Lander's interest in art began more than forty years ago when he was a resident at Cook County Hospital.

"In the 1940's, I did my art training at the original Hull House. The first piece I sculptured—which I use as a hat rack in my bedroom today—was of a bitterly crying baby," says Dr. Lander.

His sculpturing career, however, was interrupted by World War II. When he returned from service, he concentrated on developing his pediatric practice. "However, I'd relax by painting. It was a lot easier than sculpturing, and I just gave most of my paintings away."

Then, twelve years ago when visiting his daughter-in-law, an art teacher, he spotted an alabaster stone. "I asked her if I could take it home. I created a nude woman resting on her elbows and knees. Her head is down so it appears as if she's drinking out of a brook. That statue came out so well that I knew sculpturing had to be an important part of my life."

At first, just like the paintings, Dr. Lander gave his pieces away to friends and family alike. Then one day while on a vacation in Tampa, Florida, he stopped at an art gallery along the beach. Dr. Lander was carrying a small sculpture only six inches long. "Out of curiosity, I went into the gallery to see if the owner would buy my work. The owner told me that he'd have to charge between $400 and $500 for that piece. Unfortunately, he felt that his clientele wouldn't pay it. As I left the gallery I said to my wife, 'What am I doing giving my pieces away!' So three years ago, I became a pro."

Recent Chicago exhibit combines humor, history

Since that day, Dr. Lander has exhibited in many Chicago galleries and libraries. His most recent exhibit was held at the Shell Reyes Design Galleria. Dr. Lander showed serious pieces as well as pieces in the "Lander Dictionary of Cliches." For instance, one sculpture showed a nude woman's torso with a disembodied hand holding a surgical brush on the left breast. "That signifies," says Dr. Lander, "the cliche 'Make A Clean Breast Of It.' "

Many of his serious pieces at this exhibit depicted Indians. For example, one figure was of a primitive girl made of black sandstone from Virginia while two other sculptures were of Indian heads. An Indian chief stared at the exhibition's visitors with a grim expression on his face while his companion named "Old Great Spirit" looked up at the sky.

When Dr. Lander finds a particular stone for sculpturing, he will go to great lengths to get it. He recalls, "One day while vacationing in Jamaica, I saw a piece of marble that I knew I had to have. This stone weighed between 50 and 60 pounds. The only way I could get it back to my hotel was to carry it on my back and shoulders. My wife and friends refused to walk to the hotel with me. That didn't stop me."

But how was he going to bring it back to Chicago? He decided to check it in as a piece of luggage and fly it home.

Today, a sculpture made from that piece of marble is displayed in his home. There are three figures in the piece: a nude woman is kneeling with a baby in her arms, while a two-year-old child is leaning against his mother's back.

"This piece will never be available for sale. In fact," says Dr. Lander, "it's my favorite."

Lander's advice to colleagues

Just as Dr. Lander has developed interests outside of medicine, he believes that other doctors should do the same. "A doctor will burn out early in life if medicine is that individual's only interest. I tell all my residents to find a hobby or activity which completely divorces them from the profession."

Unfortunately, Dr. Lander believes that most of his young residents don't believe it's true.

"Sculpturing exhilarates me. It doesn't tire me or sap my strength. Instead, I come back to my practice with a fresh mind and a clearer perspective about my patients' problems."

One day Dr. Lander plans to retire from medicine. "Yet, I can't ever see myself retiring from sculpturing unless I become physically disabled. I'm now known as a professional sculptor, and I'm just as proud of that as I am of my medical career." ▲

The play's the thing: teaching teens about AIDS prevention

by Franklin J. Kourt



Members of the acting troupe do an improvisational skit about AIDS.

HOW DO YOU get the attention of high school students when you're trying to communicate the facts about the deadly AIDS virus?

Heeding Shakespeare's admonition that "the play's the thing," McHenry County Medical Society president Edward F. Wilt Jr., M.D., came up with a unique idea that captures the attention of young people by entertaining and informing them at the same time.

An active member of the McHenry County AIDS Task Force, Dr. Wilt was looking for a relevant way to impart knowledge to his youthful audience.

"I've found that sometimes I go out to the schools to give a talk about safe sex and I hear snickering. I'm not sure that's the right approach. So much of education seems to bounce right off them," said Dr. Wilt.

Launching the project

Having heard of a project by California migrant workers to educate children through theater about the dangers of pesticides, Dr. Wilt thought this might be translated to AIDS education. He brought the idea before the county's AIDS task force late in 1987 and that group discussed it with a similar task force at the nearby McHenry County College.

By early 1988 the concept had been put before the college's theater director, Cecil O. Johnson who, with the help of the county task force, the McHenry County Health Department and the medical society, began gathering facts on AIDS.

"Once we collected all the information, we focused the concerns of the county AIDS task force. They listed the issues they thought were most important and we worked at addressing them," Johnson said.

By April of last year, Johnson had auditioned amateur actors from both the college and the community. Once the troupe was assembled they began doing improvisational skits, which Johnson recorded and then finally edited into an hour-long performance.

The material consists of vignettes on AIDS, including sexual abstinence, attitudes about the disease and precautions. Musical numbers of professional caliber were written and performed by the college stu-

(continued on page 13)

(continued from page 12)

dents. After about a month's rehearsal, the actors put on 10 free preview performances for community and school leaders. At the beginning of the school year, the performance was booked in area high schools in the county for a modest fee that was used to help cover the production expenses and provide the actors with a stipend.

Taking the show on the road

According to Pat DelMonte, R.N., of the McHenry County Health Department and chairman of the county's AIDS task force, the show, with its fast-paced beat and lively musical numbers, was a hit with the audience.

"Some of the schools passed out an evaluation form (to the students) and from the responses we got it was quite evident that we were increasing their knowledge," said DelMonte, noting that the show has played to audiences at about half the area's high schools.

The material consists of vignettes on AIDS, including sexual abstinence, attitudes about the disease and precautions.

While the performances were very successful, touring interfered with the other responsibilities, such as jobs and studies, of the actors. The answer was to videotape the performance so it could be shown any place, any time.

The resulting tape, entitled "Prove to Me That You Love Me," will now allow for much wider distribution.

Strong support from the county medical society

"The medical society has really taken this on as a project and we're pushing it. I think it might have merit to be taken state-wide," Dr. Wilt said, adding that doctors and health department personnel have tried to attend as many performances as possible to answer questions from the audiences. The county medical society recently donated $500 to the county's AIDS education effort.

DelMonte said the videotape may have some advantage over the previous "live" performances. Since they took all or most of a full classroom period, there was little time for discussion afterward. "If the teachers want to show one or two vignettes in the classroom and follow it up with discussion, the videotape will allow them to do that."

The taped performances range from the "hip" sounding "Abstinence Rap" to the poignant musings of a mother reflecting on the AIDS-related death of her son, a segment based on the actual writings of a woman in the community whose son died of the disease.

Throughout, a profound educational message comes through, such as the lyrics from "Dean's Song," which includes the refrain:

"Ya gotta think, think, think
What's gonna happen down the road.
Ya gotta know, know, know
Which way it's gonna go
Don't ever think you don't have a choice
You can always say no
Love will always wait in the end."

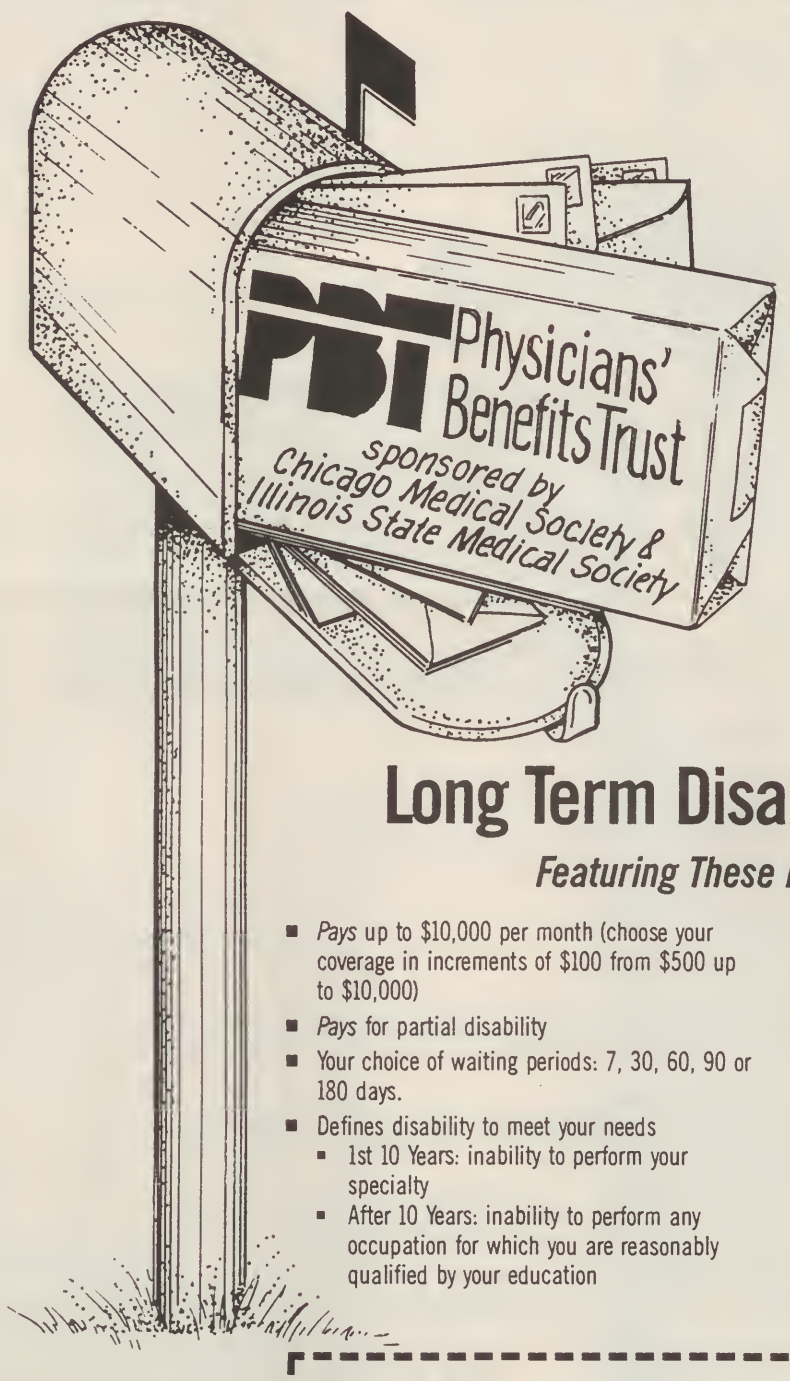
Buddy Pride, a student at the college who wrote most of the lyrics and music, called the experience of putting the show together both challenging and educational. "We created it in one month and rehearsed it in one month."

While it may never make the top of the video rental charts, "Prove to Me That You Love Me," serves its purpose well.

"When young people see someone their age discussing AIDS in a theatrical way they get into it and feel freer to ask questions," Dr. Wilt explained. And asking questions is what education is all about. ▲



Edward F. Wilt, Jr., M.D., (L) and Cecil O. Johnson, McHenry County College's theater director.



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Photo by Tim Boyle

Nearly 50 young physicians met to discuss the economics of starting out in practice at the May 20 "Business Side of Medicine" seminar.

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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

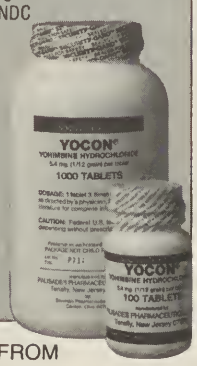
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Young physicians need law and business skills, experts advise

"IT'S GOING to be exceedingly tough for today's young physicians to build a good practice with long-term stability and suitable compensation without learning the business and legal aspects of medicine," said Saul J. Morse, Illinois State Medical Society (ISMS) general counsel. Morse's comments came during a May 20 ISMS Young Physicians Committee seminar on the "Business Side of Medicine." Held in Oak Brook, the session drew together nearly 50 young physicians statewide to discuss economics of starting in practice.

In opening the session, John Sultan, M.D. chairman of ISMS Young Physicians Committee said, "The medical practice climate is changing and there are important issues that must be faced by hospital based physicians. We need to identify these."

Other seminar presenters included John Robertson, vice president of ArcVentures, Inc.; Judee Gallagher, attorney-at-law; Robert P. Revenaugh, president of the Professional Business Management, Inc.; and W. Kent Walker, a consultant with the firm.

Joint ventures and antitrust laws

Speaking on hospital-physician joint ventures, Morse and Robertson emphasized the need for physicians to be armed with knowledge of hospital economics and finances before embarking on such plans. Robertson noted that today there are fewer hospitals, and some are financially struggling. Before establishing roots, physicians need to look at a hospital's bond rating, its financial stability, physical shape and the type of inducements available for the ancillary staff so essential to a physician's practice. "A hospital's need for a massive injection of money to maintain the physical plant will mean less available money for programs, improvements and staff," Morse added.

Joint ventures are becoming more complicated, Morse told the young physicians, and anti-trust laws are part of the reason. "Physicians can be prosecuted for violating anti-trust laws. Under these laws, a doctor or group practice cannot collectively with competitors establish fee schedules, divide practice regions, boycott third party payers or choose not to sign particular contracts in an effort to drive someone out of the market."

Contracts

Gallagher discussed the problems that "no compete clauses" can cause when doctors terminate employment contracts. A no compete clause states physicians cannot compete with their former employer within a specific area for a particular amount of time, according to Gallagher. "When evaluating potential contract agreements, physicians must think carefully about the position they'll be in if their situation doesn't materialize into permanent employment." Gallagher cautioned that noncompete clauses can force physicians to move from their established areas, incurring considerable relocation costs.

Another topic of physician concern that frequently appears in contracts, Gallagher said, is the indemnification clause. An indemnification is a promise to be responsible for someone else's liabilities and expenses, according to Gallagher. "Physicians' malpractice insurance does not provide coverage for indemnification so it exposes them to out-of-pocket costs. The clause is frequently able to be negotiated out once the contractor realizes insurance is available for the corporate organization."

Revenaugh emphasized, "Whether there's a good or bad contract, it's essential that young physicians get into a practice where the arrangement is economically viable—meaning that it's going to work. There needs to be enough income for both the young and the senior doctors, so no one is jeopardized."

"Physicians frequently underestimate their ability to work out favorable terms with HMOs and PPOs. Some HMOs and PPOs will negotiate terms even with the physician who is signing individually," says Gallagher.

Fee Profiles

Walker named different ways young physicians can determine service fees. Under the Freedom of Information Act, he said one can write Medicare and request its current fee profile for any particular specialty. Since the Medicare profile was based on 1986 charges, Walker added that Medicare's fee information is approximately 15 percent below today's current charges. He also outlined other, more accurate ways for young physicians to gauge their fees. ▲

Young physicians view tough problems

The ISMS May 20 seminar on the "Business Side of Medicine" proved "beneficial and enlightening" for many of the nearly 50 attendees.

"I think the program addresses the issues that frustrate physicians entering private practice. Unless a physician begins practice in an established group, there just isn't any basis for how to set up a practice. The business and legal aspects of medicine are not at all taught in medical schools or residency programs, yet we are thrown out to deal with certain issues when we go into practice," said Debbi Frei-Lahr, M.D., St. Louis.

Dr. Frei-Lahr looks to organized medicine as an answer to address "all the complexities the medical field today must face, including Medicare and especially malpractice because of its strong implications on where physicians will locate and what field they will pursue."

Vincent Makhlouf, M.D., Chicago, emphasized the need for the public to be more educated on physician's problems. "Because the medical field is changing and physicians must abide by more laws, there are certain aspects in medicine that may be beyond our control."

A young physician is "under forty years old, or in practice less than five years," according to John Sultan, M.D., chairman of ISMS Young Physicians Committee. ▲

Museum exhibit demystifies anesthesia

by Karen Schwartz

"THE CONQUEST OF PAIN," is a two-year-old permanent exhibit at the Museum of Science and Industry sponsored by the 1400-member Illinois Society of Anesthesiologists (ISA). According to Henri S. Havdala, M.D., chairman of the Department of Anesthesiology at Mount Sinai Hospital Medical Center, Chicago, who initiated and continues to coordinate the exhibit, the one-of-a-kind educational display is designed to educate the public about anesthesia, and in so doing allay common fears.

In 1981, the museum decided to close its anesthesiology exhibit, which had not been updated in more than ten years. Soon after, Dr. Havdala and several other ISA physicians formed a committee and approached museum officials with a plan to renovate and expand it.

Given the go-ahead, the committee encountered several obstacles. One was the prohibitive cost, estimated at approximately $320,000 to redesign. The ISA promptly stepped forward as a major financial backer, raising nearly $220,000 for the initial design, construction and equipment. Pharmaceutical companies and medical equipment industry leaders subsequently responded with additional funds and materials.

A second obstacle to launching the exhibit, Dr. Havdala explained, was disagreement over the way in which the subject of anesthesiology should be presented. The ISA committee wanted the exhibit to show that safety reigns supreme when physicians use anesthesia. "When we started to think about the exhibit in 1981, there was already a big furor in medical circles because a '60 Minutes' television program had recently done a report about the problems of safety in anesthesiology. We thus wanted to cover this subject in the exhibit."

Museum officials, however, believed that an exhibit concentrating mainly on safety could send the wrong message and frighten the viewing public instead of reassuring them. "So, in the current exhibit, we show people what we do and why we do it," and let the education process show how safety is maintained, Dr. Havdala explained.

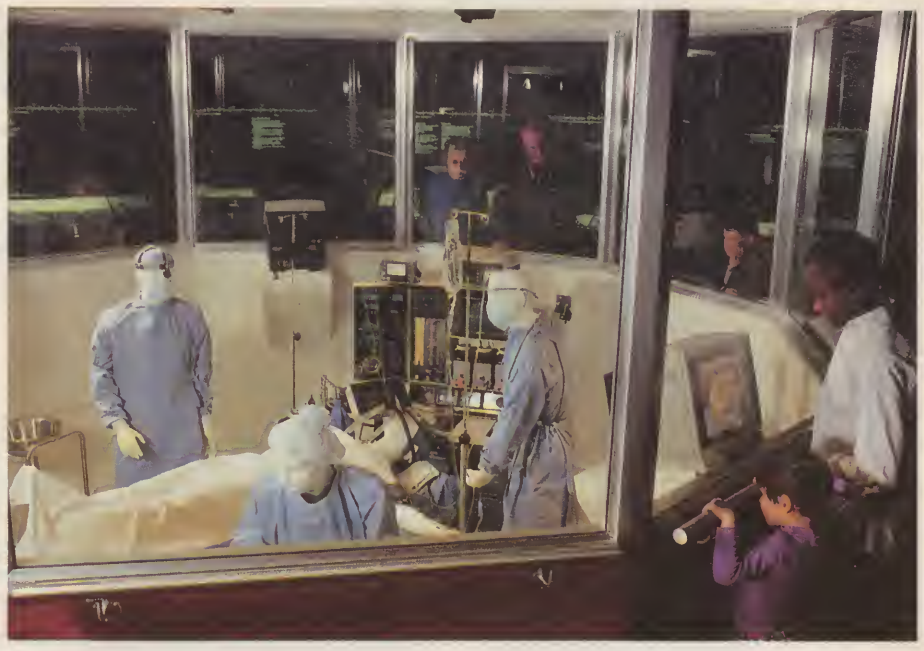
The 2400-square-foot "Conquest of Pain" exhibit formally opened March 6, 1987, with a reception at the museum. ISA members helped to introduce it to the public, explaining how the exhibit explores a patient's experience with general and regional anesthesia, and the role of anesthesiology in patient safety during surgery.

The main attraction is an actual operating room scene, which provides the basis for a video program on anesthesiology. Visitors can view and interact with actual anesthesiology equipment, as well as learn about the origins of this pain-killing specialty.

Anesthesia and childbirth are also explained, along with the many advances that have made surgery safer for the pregnant woman and her unborn child. Another part of the exhibit illustrates anesthesiology from a historical perspective, showing the monumental changes in the field of anesthesia over the past 200 years. ▲



Henri Havdala, M.D., championed the "Conquest of Pain" exhibit.



Conquest of Pain exhibit at the Museum of Science and Industry educates the public about anesthesia. (Photo above courtesy of Museum of Science and Industry, Chicago.)

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Medicare assignment

(continued from page 1)

mandatory assignment, the Illinois legislative committee of the American Association for Retired People opposed it. Senator Judy Topinka (R-North Riverside), who voted against the legislation, said the local AARP chapter in her district also opposed the legislation.

"I haven't heard from seniors" on the legislation, Topinka said.

However, she also reported a lack of lobbying by individual physicians.

"I didn't get as many letters from doctors [on mandatory assignment] as [on] tort reform," Topinka added.

Topinka said she opposed the legislation because she feared it would aggravate an already existing shortage of physicians in rural areas. She also reported that in Massachusetts, where mandatory assignment legislation was passed first, there has been a decline in the number of physicians in practice.

Senator Adeline Geo-Karis (R-Zion) opposed the legislation because, she said, "I am a senior citizen. She wants her doctor to "put in the extra mile" when caring for her. She feels physicians would lack incentive to care for seniors if forced to accept Medicare assignment.

Defeat of mandatory assignment legislation has been a major ISMS priority this year. Dr. Johnson testified against the House bill in committee, warning the legislation might cause elderly persons who could afford it to go out of state for medical treatment if physicians in Illinois began to turn down Medicare cases. He also has suggested that the legislation, if it were enacted, might result in less accessibility of primary medical care.

Illinois' Medicare representative reports 41 percent of Illinois providers accept Medicare assignment all the time. Other physicians accept assignment rates on a case-by-case basis. In all, approximately 68 percent of Medicare Part B claims are processed at assignment rates, which generally are well below usual and customary fees charged by physicians. ▲

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comment on pending litigation.

Meanwhile, the proposed agreements received overwhelming support in the Illinois House when on May 25 representatives voted 85-15 and 86-14 to approve two bills authorizing the lease, forgiving the construction debt on the eight-year-old hospital, and paving the way for UIH civil service employees to maintain their seniority and pensions when they become county employees.

However, opponents believe their cause may fare better in the Senate which must now consider the legislation. "We think that when this bill gets to the Senate, there will be much more crystallized opposition to it and much more crystallized opposition to this whole issue," said John Skosey, M.D., UIH medical staff president and an outspoken critic of the affiliation plan since it was first announced last December.

Citing the 45 minutes of debate before the vote, Dr. Skosey said that the decision was not as unfavorable to the opposition as it might seem. Noting that the House had to act on the bills by May 26 to keep them alive, he said that bill sponsor Rep. James F. Keane's (D-Chicago) promise that the bill would come back to the House for another vote once the university and the county completed negotiations on the agreements was cause for optimism.

"That encourages me that this issue is recognized as the major healthcare issue certainly in this session of the Illinois legislature, and perhaps in this decade," Dr. Skosey said. ▲

Mandatory Medicare Assignment

Senate Roll Call (S.B. 294) May 26, 1989

*Yes**

Ethel Alexander (D-Chicago)
Arthur Berman (D-Chicago)
Howard Brookins (D-Chicago)
Earlean Collins (D-Chicago)
John Daley (D-Chicago)
Miguel del Valle (D-Chicago)
Kenneth Hall (D-East St. Louis)
Joyce Holmberg (D-Rockford)
Richard Kelly, Jr. (D-Hazel Crest)
Thaddeus Lechowicz (D-Chicago)
William Marovitz (D-Chicago)
Dawn Clark Netsch (D-Chicago)
Richard Newhouse (D-Chicago)
Robert Raica (R-Chicago)
Margaret Smith (D-Chicago)
Adeline Geo-Karis (R-Zion)
Carl Hawkinson (R-Galesburg)
George "Ray" Hudson (R-Westmont)
Denny Jacobs (D-Moline)
Jerome Joyce (D-Bradley)
Doris Karpiel (R-Roselle)
Roger Keats (R-Kenilworth)
Bob Kustra (R-Des Plaines)
Richard Luft (D-Pekin)
Virginia MacDonald (R-Arlington Heights)
Robert Madigan (R-Lincoln)
John Maitland, Jr. (R-Bloomington)
William O'Daniel (D-Mount Vernon)
James "Pate" Philip (R-Elmhurst)
James Rea (D-Christopher)
Harlan Rigney (R-Freeport)
Philip Rock (D-Oak Park)
Jack Schaffer (R-Crystal Lake)
Calvin Schuneman (R-Prophetstown)
Penny Severns (D-Decatur)
Judy Baar Topinka (R-North Riverside)
Sam Vadalabene (D-Edwardsville)
Frank Watson (R-Carlyle)
Stanley Weaver (R-Urbana)
Patrick Welch (D-Peru)
Harry "Babe" Woodyard (R-Chrisman)
Greg Zito (D-Melrose Park)

*Favors assignment

No

David Barkhausen (R-Lake Forest)
John D'Arco, Jr. (D-Chicago)
John Davidson (R-Springfield)
Aldo DeAngelis (R-Chicago Heights)
Vincent DeMuzio (D-Carlinville)
Laura Kent Donahue (R-Quincy)
Walter Dudycz (R-Chicago)
Ralph Dunn (R-DuQuoin)
Thomas Dunn (D-Joliet)
Forest Etheredge (R-Aurora)
Beverly Fawell (R-Glen Ellyn)
John Friedland (R-South Elgin)

Five senators did not vote

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ISMS backs shield for clinic MDs

AN ISMS-backed bill that will protect physicians who provide services to the state's public health clinics got a big boost from the Illinois House where it passed 111-0. The bill now goes to the Senate.

According to ISMS general counsel Saul J. Morse, H.B. 1496 defines a "public health clinic" and a "standing orders physician" for the purposes of providing limited immunity for doctors under the Local Government and Governmental Employees Tort Act.

"The legislation makes clear that physicians drafting orders for public clinics would be treated as employees of a local public entity, thus entitling them to immunity under the Act," said Morse.

George Rudis, Illinois Department of Public Health chief of local health administration, said that Illinois law requires doctors to assist local public health departments when the administrator of the agency is a non-physician. Typically, that assistance has been rendered through the signing of standing orders that the clinics follow. The physicians sign the orders, but seldom see the clinic's patients.

Until recently, most Illinois physicians were willing to sign the orders with little concern, Rudis said. However, questions about insurance coverage have been arising with greater frequency because most malpractice insurers have considered the signing of standing orders an "administrative activity" and therefore not covered by malpractice insurance. Consequently, these physicians have not had any protection.

"The uninsured nature of this activity is just now becoming known, and as a result, we have county health departments that have closed their clinics because they have no signed standing orders," said Rudis.

He said the proposed legislation will extend the immunities already provided in the Act to physicians who sign the standing orders. Rudis said the legislation will also help solve a related problem. "We've got some additional health departments which have had to purchase at great cost special protection for their physicians who sign standing orders."

He said that many insurance companies offer this kind of protection, but because it is such limited coverage, it is very expensive. He said that the legislation will enable local health departments to take advantage of a provision of the Act that allows the county departments to levy a tax to purchase additional coverage. ▲

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Indigent care

(continued from page 2)

essary health care for the uninsured without inflating health care costs or undermining the business and tax climate of the state," said the report. It considered and discarded Massachusetts' universal health plan "because of its potentially adverse impact on the state's [Illinois'] budget." The report outlined no other concrete solutions, but did cite general principles from which the group will work to thrash out details by January.

Those included a sentiment that "public payers, federal and state government, were not paying their fair share of the cost of health care that government purchased" resulting in extra costs borne by private payers.

As more monies or payers participate in funding care for the uninsured, the group agreed that policy makers should reassess dollars needed. "The flow of money should not simply be based on current facilities," the report said, but on the health care demands placed on a facility.

The subcommittee also agreed to promote "rational use of the health care delivery system," citing the wastefulness of using expensive hospital inpatient or outpatient services to gain basic health care treatment.

Access and quality

Assuring patient access to health care and measuring and rewarding quality were the two goals of this subcommittee chaired by Illinois Department of Public Health (IDPH) Director Bernard Turnock, M.D. These translated into a variety of specific and controversial proposals which sparked debate at both the working group and the full summit.

On the access theme, the report suggested setting aside $25 million to fund primary care in Cook County. Some of the money would be used for a Chicago mid-south side demonstration project to build an ambulatory care center and assemble a network of hospitals and physicians providing all Medicaid and medically indigent care.

"Putting more money into community based primary care was one of the subcommittee's guiding principles," said Dr. Turnock. "We didn't come to agreement on whether increasing reimbursement rates alone [would be sufficient], or whether additional community based resources would be needed." He stressed that the $25 million set aside is "a variation on the theme that we need more money in the system, and that access to primary care is important."

But other summit members took a dimmer view of the set aside fund, noting that it would virtually ignore providers in other areas of Chicago and the state who provide indigent care without such funding luxuries. "It's easy to increase access in a single demonstration project by building a whole new system. But it's also expensive, and for that reason, impractical to replicate," commented ISMS summit representative Lerner. "Where will the demonstration project money—as well as the long term funding—come from?"

The working group also proposed expanding Medicaid eligibility for Illinois pregnant women and infants whose incomes exceed 185% of the federal poverty level. But it acknowledged this would produce little result without accompanying incentives to increase provider participation in caring for these new patients.

To assure quality, Dr. Turnock put forth an IDPH voluntary certification program for primary care centers. No specific standards were outlined. Those receiving certification would get higher reimbursement. "Raising reimbursement rates should be tied to minimal expectations of quality," he explained, "so that substandard providers don't benefit."

ISMS opposed this recommendation, said Lerner, because it would give IDPH authority to regulate activities within a physician's office.

The working group will continue to rework and refine recommendations, Dr. Turnock indicated. "The exact mix and match [of resources] needs to be sorted out by the public and private sectors, with an emphasis on primary care needs."

State medical payment policy

This group's first recommendation called for devoting new resources to upgrading payments to Medicaid providers. It also asked the Illinois Department of Public Aid (IDPA) to complete a "systematic long range reimbursement" plan by September. Data are needed on performance of Illinois' Medicaid program and the health care experience of its target population, said the report, and it recommended a collection system for future policy makers' reference.

Three other short term priorities surfaced in the report. They are "expanding and maintaining delivery of primary care for Medicaid patients, protecting critical disproportionate share hospitals and funding cost effective interventions such as the expansion of prenatal care to low income pregnant women."

Group chairman Lawlor said a final issue centered on "administrative steps IDPA could take quickly and without a great deal of funding." The agency heard suggestions on simplifying claims procedures, publishing an easy-to-read handbook and other ways to streamline administrative procedures. ▲

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Family practice—hospital sponsored clinic opportunity. Dynamic, growth-oriented hospital in beautiful north central Wisconsin is seeking two family physicians for a new clinic facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, President, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota, 55435; (612) 835-5123.

Family practice—acute care facility in central Iowa seeks family practitioner to join group. Thriving practice; two clinics with strong hospital support. Call coverage well equipped and have spacious facilities. Call Michael Krier at 1-800-332-0488.

HealthLine Physician Services, affiliated with St. Louis University Medical Center, has full-time opportunities for the following specialties: BC family practice, BC pediatrics, BC or BE internal medicine. Income guaranteed, no capital investment. HealthLine also has part-time/full-time emergency medicine, clinic, locum tenens positions throughout the St. Louis area and nearby central/southern Illinois. Paid malpractice, flexible schedules, no call, no overhead; challenging medicine. Contact: Bill Salmo, HealthLine Physician Services, 3663 Lindell Blvd., Suite 410, St. Louis, MO 63108. 1-800-443-3901.

Physician wanted. Internist or family practitioner for Chicago southside well established large medical clinic. Clinic in existence for over 15 years. Primary public aid practice. Full-time. Extremely clean and fully furnished facility. Excellent opportunity and potential. Please contact Mr. Weingart at (312) 493-8505 for details.

Wanted—Board eligible/board certified emergency medicine physician to join an emergency department staff which is part of a 200 physician multi-specialty clinic in Champaign-Urbana, Illinois; 35,000 annual visits. Liberal fringe benefits and salary lead to equal ownership. Send CV with inquiries to J. Yambert, M.D., Division of Emergency Medicine, Carle Foundation Hospital, 611 West Park, Urbana, IL 61801; 217-337-3313.

Emergency medicine—Dubuque—opening available for qualified individual to join incorporated group of three BE/BC emergency physicians. Unique and enjoyable practice, excellent compensation, complete career opportunities, and highly livable community. Write: NET, PC, c/o Mercy Health Center, Emergency Department, Dubuque, IA 52001, or call Mark Singsank, M.D. (319) 589-9666.

Psychiatrist: Community mental health center in northwest Chicago seeks psychiatrist. Responsibilities include: medication maintenance and follow-up and psychiatric evaluations. Four to nine hours per week available, must include some evening hours until 9 p.m. Available 8/1/89. Bilingual, Spanish/English preferred, but not required. Good position for recent graduate or third or fourth year resident. Contact: Val Nabolotny, Portage-Cragin Counseling Center (LSSI), 4840 W. Byron, Chicago, IL 60641, (312) 282-7800.

Pediatric Allergist (Fellowship trainee also considered) needed to help solo pediatrician, twice a month on a Saturday/weekday with allergy patients. Also needed second pediatrician to join solo practice about one hour from Chicago. Reply to box 2142 c/o *Illinois Medicine*, Twenty N. Michigan Ave., Suite 700, Chicago IL 60602.

OB/Gynecologist: Needed for old, progressive Southern Illinois river town. Minutes from urban amenities. Well-equipped new hospital, local college, high employment, this region is unexcelled. Guaranteed net income. Write or call "collect": Wendell C. Trent, DPA Administrator; Wabash General Hospital; 1418 College Drive; Mount Carmel, IL 62863; (618) 262-8621.

Surgeon: Needed for old, progressive Southern Illinois river town. Minutes from urban amenities, well-equipped new hospital, local college, high employment, this region is unexcelled. Guaranteed net income. Write or call "collect": Wendell C. Trent, DPA Administrator; Wabash General Hospital; 1418 College Drive; Mt. Carmel, IL 62863; (618) 262-8621.

Twenty-nine physician multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, M.D., Fond du Lac Clinic, S. C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

Internist or gen. practitioner BC/BE to provide internal medicine services for patients of private ophthalmology practice/surgicenter. Responsibilities will incude pre-op H & P exams, EKG interpretation, and staff employment physicals. Mon.-Fri. No nights. No weekends. No call. Send CV to Carole Melton, Hauser-Ross Eye Institute, 2240 Gateway Drive, Sycamore, IL 60178 or call 815-756-8571.

Physicians specializing in pulmonary diseases or ophthalmology needed for part-time work under contract to the Social Security Administration's Disability Programs Branch in downtown Chicago. Experience in review of medical evidence in disability claims preferred. No contact with patients. Unrestricted license in any state required. Interested parties should submit curriculum vitae by August 15, 1989 to: DHHS, Region V Contracting Officer, 105 West Adams, 22nd Floor, Chicago, Illinois 60603.

Immediate opening. One internist and one general practitioner at a 250-bed acute treatment psychiatric hospital, JCAH approved, Medicare Certified, affiliated with the University of Iowa Medical College. Forty-hour work week. No night or weekend on call. Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $81,016. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect. B.J. Dave, M.D., Superintendent, Mental Health Institute, Independence, IA 50644. PH: 319-334-2583. An Equal Opportunity/Affirmative Action Employer.

Dreyer Medical Clinic, Aurora, IL. 65 physician multi-specialty group with offices in Aurora, Batavia, Oswego and Fox Valley Villages seeking bd. cert./bd. elig. physicians as follows: int. med., child psych, Ob/Gyn, ophthal. and peds. Located in Chicago west suburban area of extensive commercial and residential growth, clinic is approximately 70 years old and highly respected. Abundant recreational activities available along the scenic Fox River. Please send information to Box #2144, c/o *Illinois Medicine*, Twenty N. Michigan Ave., Suite 700, Chicago, IL 60602.

Healthline Physician Services, an affiliate of St. Louis University Medical Center, is recruiting for an emergency department medical director and staff physicians at Hannibal Regional; Hannibal, Missouri. Growth oriented program in historic Missouri river town. Good compensation, benefits, paid liability. Part-time/locum tenens also available. Contact William J. Salmo, Healthline Physician Services, 3663 Lindell Blvd., Suite 410, St. Louis, Missouri 63108; 1-800-443-3901.

Antigo, Wisconsin: Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Central Illinois: Seeking full-time and part-time emergency physicians for two low volume facilities seeing under 7,000 visits annually. Excellent schedule and competitive compensation with paid malpractice insurance. Contact: Emergency Consultants, Inc. 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Chicago Area: Looking for emergency medicine physicians to staff moderate volume emergency department in downtown hospital. Full-time and part-time opportunities available. Fluency in Spanish desired. Competitive rates, flexible scheduling and malpractice insurance. Benefit package available to full-time physicians. For more information contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Family physician—well-equipped 48-bed rural JCAH accredited hospital is looking for a family physician to round out their medical staff. Modern furnished five room clinic located on hospital grounds provided. Lucrative financial package including guarantee for initial period. Unbelievable income potential. The hospital is located in southeastern Illinois in the midst of the Shawnee National Forest. Excellent area for fishing, hunting, boating, etc. Contact Roby Williams, Administrator, Hardin County General Hospital, P.O. Box 2467, Rosiclare, IL 62982. Telephone—(618) 285-6634.

Situations Wanted

Experienced family practitioner seeks part-time or full-time work, preferably in HMO, clinic or hospital setting in the Chicago metropolitan area. Reply to Box 2140, c/o *Illinois Medicine*, Twenty North Michigan Ave., Suite 700, Chicago, IL 60602.

Board eligible diagnostic radiologist seeks part-time position in Chicagoland and suburban areas. Call (312) 328-2759 or write Box 6283, Evanston, IL 60204.

Illinois licensed general practitioner seeks suitable opportunity in Quincy. Reply to box 2141 c/o *Illinois Medicine*, Twenty N. Michigan Ave., Suite 700, Chicago, IL 60602.

For Sale, Lease or Rent

Family practice—Busy northwest suburban practice close to many hospitals, for sale. Suitable for BC/BE family practitioner or general surgeon willing to do some general practice. High income. Available immediately. Reply to Box 2133, c/o *Illinois Medicine*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

Farm for sale. 187 acres located three miles north of picturesque Galena, Illinois. 64 acres are tillable and the remainder is pasture and dense woods. The property borders the Galena River for about one-half mile. Two dwellings are on the property: a classic 8-room farmhouse and remodeled rock school house. Ideal for a week-end retreat or retirement home. $180,000. Call (312) 828-9747.

Practices for sale: PSL, as exclusive medical brokers, is the largest California based company specializing in practice sales. Our specialized services include appraisals, financing, and physician recruitment. Request our free monthly practice list or contact us for a confidential interview. PSL, Inc., 4122 E. Chapman, #10, Orange, CA 92669. (714) 771-4431.

For sale: two exam room sets in good condition, waiting room furniture, copier, and some ob/gyn equipment. Call (618) 283-4081.

Neurometer with literature and supporting IBM software, rarely used, asking $2500.00. David Block, MD, 217-345-6051.

Entire belongings of medical center for sale: waiting room furniture, desks, examining tables, EKG, spirometry, ophthalmoscope, supplies, lamps, lab equipment, Ames chemistry analyser. Call A. Polussa, M.D. 684-3300.

Established family practice fully furnished for sale/ rent. Southside public aid area. Leaving the state, grossing $100,000. Asking $650/month, $3000 security. Call A. Polussa, M.D. 684-3300.

"Get paid for what you do." Best selling manual on how to get maximum reimbursement from insurance companies and Medicare. $45.00 postage paid. "ICD-9 quick reference" 313 most commonly used diagnosis codes. Now required by Medicare. Permanently laminated plastic. $7.95 PMC, 8 Jaime Lane, O'Fallon, IL 62269.

Used Medical equipment. Examination tables, EKG, ophthalmoscope, otoscopes, copy machine, audiometer and many small items. Call (217) 932-4425.

General and Cosmetic Surgical Practice—Clean surgical practice, established 20 years, extensive referral from local physicians and surrounding communities. Established office, all equipment and furnishings available. Central southern Illinois. Universities, recreational facilities, metropolitan areas all easily accessible. Contact E. F. Stephens III, M.D, P.O. Box 1225, Centralia, IL 62801, (618) 532-9220.

Illinois-Waukegan-Free Rent to start—Beautiful medical office—Prestigious modern building. Excellent busy location. Three exam rooms, lab, private office, two washrooms. Free off-street parking. Near three hospitals. (312) 662-1664.

Dolton, IL Area: Practice, equipment and real estate are available. Owner has passed away and a part time physician has been grossing $5,000 per month on a very limited schedule. It is estimated that a full time physician could generate $250,000-$300,000. There are hundreds of patient files. The package is available for $137,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093. (312) 441-6111.

Miscellaneous

Photography: Publication prints, lecture slides, duplicates, overhead transparencies, exhibits. Technical competence, design sense, many publications to credit. References. Portfolio, Images, 850 Cornelia, Chicago, 60657. (312) 327-2246.

$5,000-$60,000: For physicians unsecured signature loans. Available for debt consolidation, investments, tuition, relocations, purchase of medical practices or any need including taxes. Level payments up to six years. No prepayment penalty. For application call toll free: 1-800-331-4952, Dept. 114, MediVersal.

Title: Orthopaedic Conference: New Perspectives in Pediatric Orthopedics, An Update. Date: October 5-7, 1989. Location: Landmark Resort in Egg Harbor, Wisconsin. Speakers: Alan L. Breed, M.D.—Madison, WI; Alvin H. Crawford, M.D.—Cincinnati, OH; Paul Esposito, M.D.—Omaha, NE; John J. Hugus, M.D.—Marshfield, WI; Walter W. Huurman, M.D.—Omaha, NE; F. Stig Jacobsen, M.D.—Marshfield, WI; David C. Mann, M.D.—Madison, WI; H.A. Peterson, M.D.—Rochester, MN; George W. Simons, M.D.—Milwaukee, WI; John G. Thometz, M.D.—Milwaukee, WI; Virginia Garnett-Wintersteen, M.D.—LaCrosse, WI. Further information: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. (715) 387-5207.

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STABLE

In an unstable professional liability climate, a stable insurance carrier is a **must**. Nearly 10,000 physicians have found a cornerstone of security in the Illinois State Medical Inter-Insurance Exchange, the state's first and largest physician-owned professional liability insurer.

The Exchange is the only carrier in Illinois which has continually offered coverage to new applicants since 1976. Our record is one of commitment to policyholders. That has sometimes meant difficult decisions, such as converting to claims-made insurance, setting realistic premiums and adhering to tough underwriting standards. That commitment—and these decisions—allowed the Exchange to stand firm when others were abandoning Illinois physicians.

AGGRESSIVE

Policyholders depend on the Exchange for aggressive defense. Claim examiners direct and monitor the legal team to see that the physician's voice is heard and that the defense is diligent, efficient and speedy. The Exchange continually audits its defense firms to enforce strict performance standards.

But, there is no better defense than prevention. The Exchange's loss prevention program helps physicians learn not only how to prevent suits, but also what steps to take for the best results once a claim or suit is filed.

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The Exchange exists for the Illinois physicians it insures. Its priorities are diligent claim management, careful underwriting and fiscal responsibility. A commitment to long-term vision, tempered by flexibility, will ensure stability and help to keep rates down. That commitment is a cornerstone of security for Illinois physicians.

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Illinois Medicine

June 23, 1989 ILLINOIS STATE MEDICAL SOCIETY

Court strikes certificate of merit

THE FIRST district appellate court June 13 ruled unconstitutional the certificate of merit required to file medical malpractice lawsuits in Illinois. The decision, written by Justice Anthony Scariano and concurred by justices Michael Bilandic and Charles Freeman, is binding on all Cook County medical malpractice cases. The certificate is still needed in every other part of the state.

The certificate of merit law mandates that all medical malpractice complaints filed in court be accompanied by a health care provider's certificate attesting to the lawsuit's merit. Passed in 1985 as part of comprehensive medical malpractice reform legislation, the requirement is partially credited for the large decline in lawsuit filings following its enactment.

"The decision is a significant setback for the 1985 medical malpractice reforms achieved by the medical society," said Illinois State Medical Society (ISMS) president Eugene P. Johnson, M.D. He voiced hope that the new precedent would be challenged by appeal to the Illinois Supreme Court. "ISMS stands ready to help restore this reform," he said.

Judicial vs. nonjudicial authority

In *DeLuna* v. *St. Elizabeth's Hospital and Michael Treister, M.D.*, the plaintiff filed suit without a certificate of merit, and the trial court dismissed the case. Upon appeal of the plaintiff, the appellate court reversed the dismissal saying the certificate requirement "takes away from the court altogether a vital decision-making function and confers it upon the members of a private professional group who hold in their hands the keys to the courtroom itself."

The court also said that, by mandating the certificate, the legislature intruded into judicial authority.

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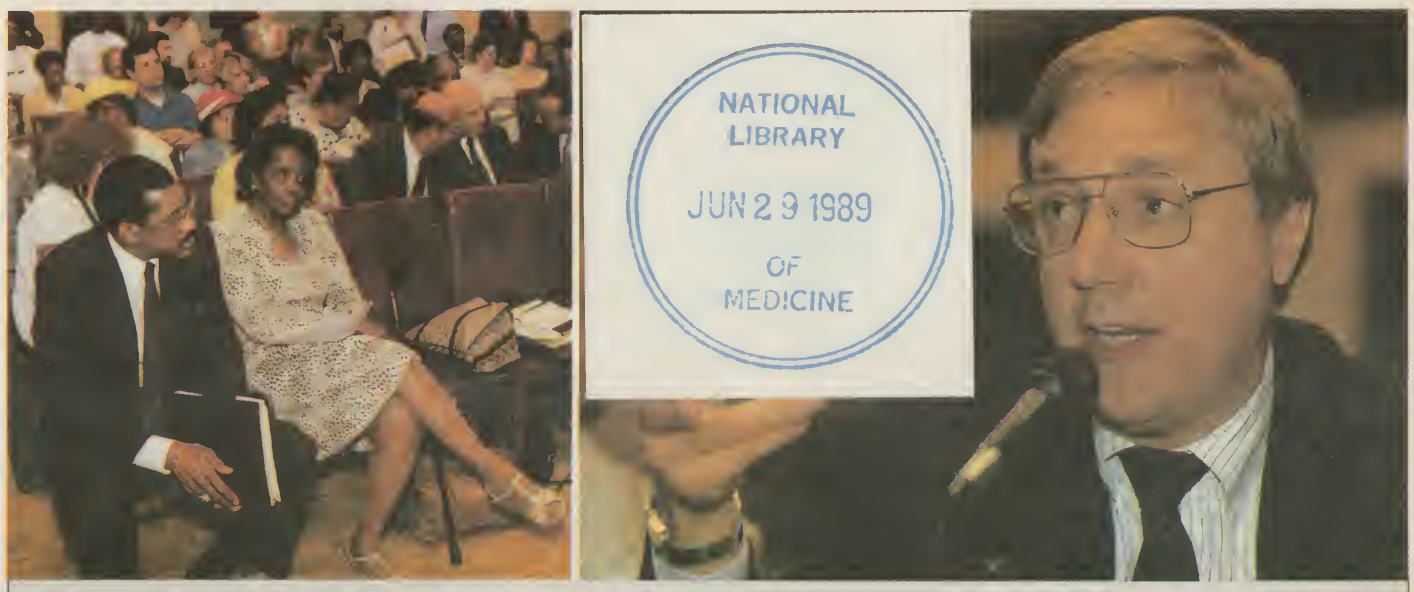
ISMS-backed bill bars bias against foreign medical grads

LEGISLATION barring discrimination against foreign medical graduates has advanced to the Illinois Senate floor for consideration after unanimously clearing the Senate Committee on Insurance and Licensed Activities June 8. H.B. 1425 makes it "inappropriate to discriminate against any physician because of national origin or geographic location of medical education."

The bill's language reiterates exactly Illinois State Medical Society (ISMS) policy adopted in 1985 by the organization's House of Delegates. "ISMS is pleased with progress of the measure thus far, and we are hopeful that it will be enacted into law before the General Assembly adjourns," said ISMS President Eugene P. Johnson, M.D., a family physician from Casey. The full Senate is slated to vote on H.B. 1425 by June 23. If approved, the bill then moves to the House for consideration.

Aldo Pedroso, M.D. a Chicago pathologist who graduated from the Havana Medical School in Havana, Cuba, thinks the law is a necessary and welcome improvement. "There is still some discrimination," he noted, "Although not as much as in

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Cook County Hospital Director Terrence M. Hansen (right) testifies at Senate Public Health, Welfare and Corrections Committee hearing on UI/Reese/County affiliations as Midwest Community Council Chairman Nancy Jefferson and others look on. Story on page 18.

Photos: Ron Ackerman

MDs must collect sales tax; possible back tax liability

by Kevin O'Brien

PROFESSIONALS, including physicians throughout Illinois recently received a "Dear Taxpayer" letter from the Illinois Department of Revenue. The letter informed them of changes in the service occupation tax that, for the first time since the tax was established in 1961, will require them to collect sales tax on merchandise that they sell or transfer through their service or practice. The letter also instructed affected taxpayers who are not currently registered with the department for sales tax purposes to do so by January 1, 1990.

About a week later, the department informed the Illinois State Medical Society (ISMS) of a voluntary disclosure program that may permit some taxpayers who owe back payments to be granted a reprieve from interest and penalties *provided they register with the department and file an appeal by August 15, 1989.*



In a letter to ISMS, Department of Revenue Director Roger D. Sweet said "Within the medical industry there is apparently widespread lack of knowledge about the taxes owed by some practitioners. As a result, some may not have been registered and paying the tax properly."

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CHIP insurance plan gets lackluster response from potential participants

by Kathleen Furore

APRIL 28—the date originally selected for a lottery to determine the recipients of the 4,000 policies available under Illinois' new Comprehensive Health Insurance Plan (CHIP)—has come and gone. And surprisingly, it has done so *without* the need for the drawing so many state officials predicted would be necessary.

In spite of some 125,000 applications circulated throughout the state and more than 20,000 phone inquiries answered, fewer than 2,000 applications for the state-backed health insurance program had been received by the April 21 deadline.

Low response explained

According to Lloyd Rice, assistant deputy director of the Illinois Department of Insurance, this unenthusiastic and unanticipated response has been due, at least in part, to consumers' misperceptions about CHIP's purpose and cost.

"We have found from phone conversations with consumers that there was somewhat of a mistaken impression that CHIP was a low-cost aid plan, irrespective of the good educational materials that were available [about the program] in print, on radio and on TV," Rice commented. "People took one look at the rate chart and said, 'I think I'll take my chances.' "

That rate chart for CHIP—the program established by Illinois legislators in 1988 to assist medically high-risk individuals who previously had trouble obtaining insurance in the private sector—was tightly underwritten and, as mandated by the legislature, carries premiums set at 135 percent of the state's open market costs for individual and small group health insurance plans.

Those annual premiums, as explained by CHIP board member Howard Bolnick in the March 17 *Illinois Medicine*, average $2,926 per person, with the program's total claims and expenses averaging $5,845 per enrollee. The $2,919 per person deficit is covered by general revenue funds which include a $5.8 million start-up appropriation (that helped secure the initial policies) and a proposed $12 million budget that, if passed, will fund CHIP for fiscal 1990 which begins July 1.

With the support of Senator Howard Carroll (D-Chicago), who introduced S.B. 12 calling for the $12 million appropriation, Attorney General Neil Hartigan and the Illinois Department of Insurance, things are "looking good" for its passage according to Rice. As of June 6, the bill was in the House Appropriations Committee. Rice also expressed positive feelings about the available funds, particularly in light of the level at which applications have been and continue to be received.

"Only 2,318 applications had been received as of May 22, which amounts to 25 applications a day or less since the first of May," said the assistant deputy director. "We are breathing more easily . . . because if the applications level off at around 3,000 [instead of at the cap of 4,000], we will be able to invest the reserve to generate earnings."

Current application status

That enrollment cap of 4,000 initial policies, which was set based on an actuarial analysis of similar state and private programs, leaves room for more than 1,000 people to file applications for the state-subsidized health insurance plan. And while a deadline no longer exists, Rice is quick to emphasize that the limit of 4,000 policies will not be exceeded.

"People can continue to apply [for CHIP] on a first come, first served basis," he said. "But 4,000 is a firm number. We won't increase that cap until experience tells us the money appropriated will take care of more. It's too much of a gamble, and we need something on the claims books before we can proceed."

The people already in CHIP and those still able to apply include Illinois residents ineligible for Medicaid who can prove they have been rejected by an insurance company because of a pre-existing condition, individuals who have been offered similar coverage through a commercial health plan but at a rate higher than that CHIP charges, and those with certain presumptive conditions.

CHIP Qualifying Medical Conditions

Persons with one of these qualifying medical conditions need not obtain a letter of rejection from an insurance company to buy CHIP coverage.

- Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
- Angina pectoris
- Arteriosclerosis obliterans
- Cerebrovascular accident (Stroke)
- Chemical dependency
- Cirrhosis of the liver
- Coronary insufficiency
- Coronary occlusion
- Cystic Fibrosis
- Friedreich's ataxia
- Hemophilia (classical)
- Hodgkin's disease
- Huntington's chorea
- Juvenile diabetes
- Kidney failure requiring dialysis
- Leukemia
- Lupus erythematosus disseminate
- Metastatic cancer
- Multiple or disseminated sclerosis
- Muscular atrophy or dystrophy
- Myasthenia gravis
- Myotonia
- Paraplegia or quadriplegia
- Parkinson's disease
- Poliomyelitis
- Polycystic kidney
- Severe traumatic brain injury
- Sickle Cell Anemia
- Silicosis pneumoconiosis (Black Lung)
- Syringomyelia
- Wilson's disease

Persons with other medical conditions may also be eligible for CHIP, but must submit a letter of rejection for similar coverage from an insurance company.

Source: Illinois Dept. of Insurance and the Office of the Attorney General.

A plan overview

CHIP members are covered for approved services up to $500,000 per person by CHIP policies, which carry annual deductibles of $500 or $1,000 for individuals. Policyholders are responsible for twenty percent of their medical bills above the deductible; but once out-of-pocket limits (which Rice says will not exceed $2,500) are met, there are no limits on services and treatments rendered, except for skilled nursing facility and home health care, hospice services, and treatment of mental and nervous conditions. Pre-existing conditions are covered six months after the policy goes into effect; maternity benefits and supplemental Medicare coverage are offered as an option; and there is even a "buy-down" clause that allows policyholders to start receiving coverage on pre-existing conditions two months from the policy's inception with the payment of a permanent 10% surcharge.

Although insurance claims, complaints and cost containment procedures are handled by Mutual of Omaha, CHIP's administrator, the Illinois plan differs from those offered in fifteen other states in that it is funded by the state—not by licensed insurers who are assessed a portion of the program's cost proportionate to market share.

As Rice explained, "The insurance industry plays no part in it [CHIP] in Illinois. The lobby here prevailed, and the General Assembly agreed that since the program is an answer to social problems, general revenues should be used to support it."

For more information about the Illinois Comprehensive Health Insurance Plan or to request an application, write to: Illinois CHIP, Box 20, One Westbrook Corporate Center, Westchester IL 60154; or phone the office toll-free at 1-800-456-0224. ▲

Physician Facts

Fireworks Injuries in Illinois

Type	1986 Total: 415		1987 Total: 390		1988 Total: 359	
	#	% of Total	#	% of Total	#	% of Total
Legal						
Sparklers	55	14	36	9	47	13
Smoke Bombs	15	3.5	11	3	9	2.5
Fireworks Displays	36	8.5	39	10	13	4
Illegal						
Roman Candles	15	4	17	4	13	4
Bottle Rockets	45	11	43	11	56	15.5
M-60/M-80/M-100	31	8	39	10	59	15
Firecrackers	144	34.5	145	37.5	75	21
Other Fireworks	31	6.5	25	6.5	36	10
Unknown	43	10	35	9	51	14

Source of Data: Office of the Illinois State Fire Marshal.

ISMS MD to serve on ethics panel

ISMS Trustee Jere Freidheim, M.D., will serve on the recently announced Task Force on the Removal of Life Sustaining Treatment. Cook County State's Attorney Cecil A. Partee established the 43-member task force to study ethical and legal questions prompted by the Rudy Linares case.

A grand jury refused to indict Linares who on April 26 unplugged his 15-month old son from a respirator while holding physicians and nurses from Rush-Presbyterian-St. Luke's Medical Center at gun-point.

"The Linares case is now closed," Partee said. "But the issues raised by that affair are very much alive." Partee said the task force would study when death occurs, under what circumstances it is appropriate to remove life sustaining equipment, what procedures should be followed



Jere E. Freidheim, M.D.

before disconnecting such systems, and who decides.

"Ideally, this information will inspire the enactment of legislation," Partee said.

Dr. Freidheim told *Illinois Medicine* that while the task force's study is worthwhile, he opposes any legislative remedy. "In my view, it would be ludicrous for the state to step into such highly personal physician-patient decision-making." ▲

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On the Legislative Scene

by Caryl Carstens



Smoking limitations . . . Clean air legislation controlling smoking in public places is before the Senate after passage in the House. While H.B. 120, sponsored by Rep. Robert Terzich (D-Chicago) and supported by ISMS, was held in the Senate Executive Committee, a second piece of legislation, H.B. 1695, also supported by ISMS, was approved by the Senate Executive Committee and is awaiting floor action. Sponsored by Rep. John Dunn (D-Decatur) in the House and Sen. Bob Kustra (R-Des Plaines) in the Senate, the bill would prohibit smoking in areas open to the public, except for areas set aside for smokers. It would apply to state and local government offices, places of employment open to the public and other public areas. Smoking also would be prohibited in schools. Supervisors of such facilities may set aside enclosed areas where smoking is permitted.

The Senate committee amended the bill to relax the prohibition so that it does not apply to factories or warehouses and similar work areas not frequented by the public. The committee also voted to preempt the authority of home rule governments to pass ordinances controlling smoking unless the ordinances were in effect before May 31, 1989. Both amendments must be approved by a full Senate vote to become part of the legislation. The bill was reported to be agreed to by the tobacco industry and public health groups, although some business organizations may oppose it, a committee staff member said.

Repeated violations may be the basis of a circuit court action to enjoin the violator from future infringements.

Pre-marital AIDS testing . . . Other legislation pending in the Senate for a final vote includes H.B. 18, sponsored in the House by Grace Mary Stern (D-Highland Park), and in the Senate by William Marovitz (D-Chicago), which would remove the premarital AIDS test as a requirement for receiving a marriage license. The legislation also would do away with the requirement for a syphilis test.

Medicare appeals of hospital discharge . . . H.B. 302, sponsored by Rep. Peg McDonnell Breslin (D-Ottawa), would require a 24-hour notice of discharge to hospitalized Medicare patients who have Part B coverage. The notice would include information on how to make an appeal and where the appeal may be made. The legislation has passed the House after introduction by Senator Penny Severns (D-Decatur).

Injury registries . . . A proposal to establish a registry of head and spinal cord-injured persons in the state Department of Public Health has passed the House and is pending in the Senate after committee approval there. H.B. 601 is sponsored by Rep. John J. Cullerton (D-Chicago) and Senator William Marovitz (D-Chicago). Under the law, hospitals would be required to report such cases to IDPH, which would prepare an annual report. Confidentiality would be maintained in regard to the patient's identity. An advisory council on spinal cord and head injuries would be established.

Social worker reimbursement . . . Pending in the House is S.B. 577, sponsored by Senator Emil Jones, Jr. (D-Chicago), which would add licensed clinical social workers to the professionals who may be reimbursed directly for treatment of a patient suffering from emotional, mental or nervous disorders. The legislation was approved by the Senate and sent to the House floor for introduction by Rep. William Shaw (D-Chicago), after approval by the House Insurance Committee. ISMS opposes it. Similar legislation was killed by the House.

Drug abuse programs for expectant mothers . . . Legislation which would set up the machinery for early intervention in cases where drug addicts or alcoholics become pregnant is pending in the House after passage in the Senate. S.B. 619, sponsored by Senator Earlean Collins (D-Chicago) and introduced in the House by Rep. Anthony Young (D-Chicago), requires the Department of Alcoholism and Substance Abuse to establish a care and treatment program for pregnant addicts, and addicted mothers and their babies. S.B. 613 would require pregnant addicts and addicted mothers and children to participate in the program. The bill is sponsored by Senator Earlean Collins (D-Chicago) and Rep. Lovana Jones (D-Chicago). ▲

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REPORT FOR *Illinois Physicians*

SAME-DAY ADMISSION FOR SURGERY

Numerous studies have confirmed the efficacy of admitting patients to the hospital on the same day that surgery is scheduled. Same day surgical admissions are entirely compatible with high quality care, and with the needs of house staff training programs. Same day surgical admissions have also been popular with patients, since they can spend the night before surgery in the comfort of their homes. The incidence of the need to cancel surgery, because the patient ate or otherwise did not properly follow instructions, is very low. Consequently, costs associated with admissions one or more days before surgery, will not be covered when we find that the early admission was for the convenience of the patient or the physician.

The following are conditions and procedures in which admission one or more days prior to surgery generally would be medically required.

1. Cardiovascular Surgery
   - — Coronary Artery Bypass Graft
   - — Aorto — Femoral — Popliteal bypass
   - — Repair of Aneurysm, Intra-Cerebral, or Aortic
   - — Cardiac Valvular Replacement
   - — Carotid Endarterectomy
2. Craniotomy
3. Organ Transplantation
4. The patient's medical condition requires inpatient treatment or stabilization before surgery. *Examples* of such conditions are as follows:
   - — Poorly controlled insulin dependent diabetes melletus
   - — Congestive heart failure
   - — Far advanced renal or hepatic failure
   - — Severe, current arrhythmia
   - — Required pre-operative blood transfusions, or administration of parenteral blood products
   - — Required adjustment of significant medications (anti-coagulants, steroids, insulin)
   - — Severe, chronic systemic disease (ASA Class 3-5)
5. Patient is physically or mentally unable to undergo a required pre-operative preparation on an outpatient basis, even with help from a home health aide, or the pre-operative preparation is so complex that outpatient preparation is not feasible.

(This report is a service to the physicians of Illinois)
6/9/89

Editorials

Erasing progress with the strike of a gavel

A recent court decision points out that the tort reform journey is arduous, with many rocky detours.

The first district appellate court in Cook County ruled unconstitutional a state statute requiring that malpractice lawsuits be certified by physicians as meritorious. In doing so, the court took a big step backward from the hard-won progress of Illinois' 1985 tort reform movement. The court totally opposed its own judicial colleagues in three other appellate districts who have already unanimously upheld the statute.

The decision is a serious setback for physicians and patients who seek fairness in the court system, and for the future of tort reform. We agree that legal experts must argue and decide courtroom issues, but removing the need for physicians to evaluate the medical merits of pre-filed cases will only make it easier for frivolous lawsuits to be brought. Unnecessary lawsuits do not represent a victory for patients, physicians, or the already encumbered legal system.

We hope the Illinois Supreme Court agrees to hear an appeal of the decision.

This court decision makes another indelible point: we need to be continually vigilant to protect the reforms ISMS achieved in 1985. As we see, it's all too easy to lose them with just a strike of a judge's gavel.

Some people need friends more than others

Abused children represent the silent shame of this—and countless past—generations. Crossing all societal strata, child abuse is a major American health issue, with shocking statistics showing that the largest cause of injuries to children is their parents. Fortunately, child abuse is no longer just a shameful family secret. It is a serious medical, social and political issue that demands prompt redress. As an example, a story in this issue shows that public and private entities are aggressively seeking protection for neglected children, and punishment for their abusers.

Physicians need to step forward as abused children's best friends. With legislation now in place protecting physicians acting in good faith from civil prosecution, we can offer significant help. Medical expertise can uncover evidence of abuse—frequently difficult to detect—for children who can't speak for themselves. We can intervene with legal protection to provide for or even assume protective temporary custody of a child we suspect is abused, without having to wait until abuse is confirmed by further injury.

Most important, we can help reduce the potential for child abuse by counseling parents and potential parents. We can also help those at risk of becoming abusers because of their own childhood experiences. As physicians, we're charged with the moral and professional obligation to improve quality of life and reduce suffering wherever and however we can. Protecting youngsters from child abuse is essential to fulfilling that responsibility. ▲

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"You appear to be perfectly sound."

President's Column

Medical malpractice: Is the giant dead?



Eugene P. Johnson, M.D.

"Costs of Medical Malpractice Drop After an 11-Year Climb" announced the June 11 *New York Times* headline. That's good news for us and our patients, in Illinois and nationwide. The $100 million drop since 1987 in the cost of resolving malpractice claims, as reported in the *Times,* came about for several reasons. Most prominent among them is the hard work of physicians to change the system. We should look with special satisfaction upon what we've achieved in Illinois. We were one of the first states to reverse the trend. Others copied our efforts.

Let's not rest on our laurels. The 'crisis' may have waned, but it's not over. We still have work to do.

Within our own house, we must continue to strive for better risk management to prevent lawsuits from happening in the first place. That means strong commitment to quality health care, sensitive handling of patient relations by us and our staffs and care with medical recordkeeping. It also means having the courage to discipline incompetent peers, and to press impaired colleagues toward rehabilitation.

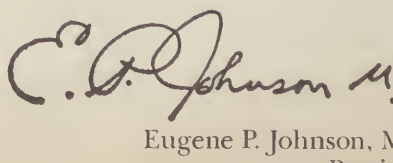
In Illinois we've strengthened the medical disciplinary law to aid our profession's commitment to discipline. We're building awareness among physicians of the most common reasons patients file lawsuits—whether or not due strictly to negligence. This has laid the groundwork for us to reduce further the incidence of medical malpractice. We should take advantage of it.

Outside the profession, we have made great progress in educating the public about malpractice litigation costs—in terms of health care access, quality and price. The public has responded with support for tort reform, and empathy for physicians caught in a web of conflicting pressures. We need to continue earning that understanding—through education beyond our ranks.

Still eluding our grasp are caps on non-economic damage awards, the reform most essential to long term solution of Illinois' medical malpractice woes. Achieving caps will require the profession's and our patients' total, unified commitment. It's an enormous task which lies ahead.

Finally, in the glow of a generally improved medical malpractice climate, let's not forget that large pockets of Illinois are still experiencing problems. Medical malpractice costs—still relatively high for many rural physicians—combine with low Medicaid reimbursements to present seemingly insurmountable financial obstacles. Many communities do without physicians. Babies are still being born along the roadside, as Southern Illinois patients rush toward OB care available only outside Illinois borders.

Yes, there's cause for encouragement that the medical malpractice crisis is easing. But we haven't killed the giant. Let's not be lulled into complacency. ▲



Eugene P. Johnson, M.D.
President

Guest Editorial

Why lawyers should not practice medicine . . .



by Steven H. Miles, M.D.

The specter of Samuel Linares and how he died at a Chicago hospital will haunt his family long after the media lay him to rest. For now, the known facts come readily to mind. A baby is comatose after choking on a balloon at his home last August. When the prognosis is clear, the family asks that the respirator be disconnected and their son be allowed to die. The hospital lawyer says that the hospital must continue treatment to minimize liability for "murder or child abuse." The anguished indigent family is told to undertake a complex and costly court procedure to terminate care. Months pass. The hospital ineptly communicates the finality of plans to transfer the child to a nursing home on the respirator. With a gun, the distraught father asserts his custody of the child: he removes the respirator and his son dies in his arms. The public heart is with the family and the father is freed with a suspended sentence on a minor charge.

While many features of this story warrant exploration, the involvement of the hospital lawyer in the clinical decisions is a striking aspect of this tragedy. It appears that the hospital lawyer's advice stalled the progress of discussions with the family on the clinical management of the respirator. Based on experience with similarly inclined attorneys at other hospitals, I believe that the role of the attorney can be seen as deficient in a broader perspective.

- His involvement marked a momentous reconstruction of the foundation of treatment decisions: from a patient or family-centered compassionate medical judgment toward the hospital's interest. Doctors are accountable to a patient's interest; they expect no sympathy if they subordinate a patient's care to personal concerns or administrative expediency. When Samuel Linares' doctors asked the hospital lawyer, "Can we discontinue life-support?," I doubt that they understood the degree to which the lawyer's opinion, unlike a medical consultant's, was a subjective interpretation which reframed the clinical issue in terms of the hospital's interest. Reconciling clinical care with public policy might have been better done by a trained medical ethicist, who retained a patient-centered perspective.
- His reading did not accurately reflect the public, professional, and judicial consensus about treating the permanently comatose. No hospital has been successfully prosecuted for termination of treatment in this circumstance. There is no surer proof of this consensus than the rapidity with which public, professional, and judicial compassion developed for Rudolfo Linares after his action, which with another face, might have been construed as terrorism.
- His view was cynical. It held that prosecutors would capriciously rush to magnify this tragedy if the ventilator was disconnected. It counted on public indifference to the hospital holding the Linares' child for months of unwanted intensive care over his parent's objections, without bothering to obtain legal custody. It stonewalled an indigent and unsophisticated family with a requirement to get a court order which the attorney surely knew that Illinois courts were unprepared to process.

Physicians will not be surprised that this kind of clinical approach presages a clinical care disaster. Lawyers who enter active clinical care might learn that this type of intervention no longer can be relied on to serve their client's interest either.

. . . and why doctors must.

There is little doubt that physicians and family free of caricatured liabilities could have quietly and legally removed life-support that all agreed was no longer healing. It is not clear the Linares' case should necessarily lead to new laws. Legislation cannot replace clinical judgment. It cannot make these decisions less challenging. It will not eliminate the possibility of negligent, and therefore legally culpable, care.

New laws could make things worse. They would create additional procedural liabilities. In New York, such protection for a medical profession that was unwilling to shoulder its responsibility, has made legal do-not-resuscitate orders nearly impossible to write. They could shift the heart of clinical decisions from those who live and weep with them to imperious meddlers. In New Jersey, the state office that supervises limited treatment plans has been hijacked by a political sect that does not recognize (as patients, families, and doctors do) that the end of life should be managed with medical restraint.

Our society entrusts its professions and secondary institutions with responsibilities which are not amenable to political or bureaucratic processes and formulae. Doctors practice a complex art at the difficult juncture where life is both precious and mortal. Parents make the individual decisions about raising children in fortune and misfortune. Perhaps the saddest and most important fact of the Linares case is that, had the doctors been correctly informed of the scope of their discretional powers and permitted to exercise the clinical judgment that society expects of them, the death of Samuel Linares would not now so haunt his family or the reputation of the hospital where he died. ▲

Dr. Miles is assistant professor of medicine and associate director of the center for clinical medical ethics at the University of Chicago Medical School.

Letter to the Editor

Medical Disciplinary Board

I am responding to the letter written by William Schuler M.D. of Mendota which appeared in the May 26 *Illinois Medicine.*

When I was appointed to the Medical Disciplinary Board in 1984 along with two other members who were physicians, the members of the board were residing in Mt. Vernon, Alton, Carbondale, Belleville, Peoria, Champaign, and the other three were from the Chicago area. Mt. Vernon is in Jefferson County and Carbondale is in Jackson County. Both are considered rural counties of Illinois.

In 1985 the member from Belleville was replaced by a physician from Galesburg and the member from Alton was replaced by a physician from the Chicago area. The area around Galesburg is also considered rural.

Being 100 miles away from a CT scanner or 50 miles away from one who does obstetrics has nothing to do with the qualifications for being recommended, appointed and confirmed as a member of the Medical Disciplinary Board.

Charles K. Wells, M.D.
Mt. Vernon

Dr. Wells served as Chairman of the Medical Disciplinary Board.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

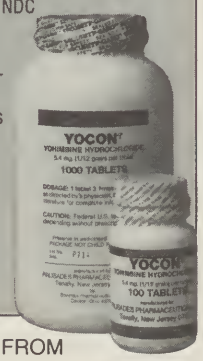
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Illinois Supreme Court rules on voluntary dismissals of lawsuits

MEDICAL MALPRACTICE cases may be less frustrating since a February, 1989 landmark decision by the Illinois Supreme Court altering the ability of plaintiffs in lawsuits to dismiss and subsequently refile a case. The decision involved three consolidated cases in which trial court decisions entering summary judgments for the defendant were previously reversed by the appellate court. The cases included *Gibellina* v. *Handley* and *Ware* v. *Central DuPage Hospital,* both medical malpractice cases, and *Schmitt* v. *Motorola,* a product liability case.

The cases urged a change in Illinois' voluntary dismissal procedure, in order to curb abuses, explained Thomas Fegan, partner in the Chicago law firm of Johnson, Cusack and Bell, Ltd., and an appellate counsel in the litigation. That procedure gives plaintiffs an absolute right to voluntarily dismiss their case anytime prior to trial, so that in case of a technical defect, such as being unable to locate witnesses, the plaintiff doesn't lose the right to trial at a future date, he said.

"The original purpose was to allow the plaintiff to correct any procedural or technical defects without losing his cause of action on merely technical grounds. However, the procedure began to be used instead for the purpose of avoiding attempts by defendants to dispose of cases on the merits," Fegan explained. Under these circumstances, "the plaintiff's attorney could voluntarily dismiss the case and refile it against the same doctors within one year and start all over again," he said.

"As defense counsel representing physicians, we would bring a summary judgment motion [to end the case forever], with affidavits showing there was no negligence [by the defendant physician] and that the plaintiff had no proof or expert witnesses. Rather than arguing with our motion, if the plaintiff expected to lose, he would just dismiss the case. Then, eight months later he would refile the suit, and we would have to contact the defendants telling them they were again in jeopardy and start taking depositions and getting witnesses again," said Fegan. "We felt this was an abuse of the procedure," he added.

The Supreme Court decision changes the procedure, so that if a defense motion which would end the case is made, the judge has the option or discretion to hear that motion first. "In the past, he didn't have that option," Fegan commented.

"I'm very pleased with the change in the law," said Philip Boren, M.D., a board member of Illinois State Medical Insurance Services (ISMIS), and chairman of its physician review committee. "It helps assure fairness and prompt justice for defendants, and is designed to put a stop to abuse of the voluntary dismissal rule." ▲

Guest Editorial

Voluntary dismissal no longer automatic

by George W. Spellmire, Jr., and Ellen L. Zopff



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Until recently, the following was a familiar scenario in medical malpractice cases. The defense attorney would ask the judge to rule on the case before it went to trial, maintaining that the plaintiff had failed to produce expert testimony on the defendant's alleged malpractice. If the judge agreed to hear the defense's motion for summary judgment, it meant the possible end of the lawsuit. The plaintiff, attempting to avoid the motion, would ask for voluntary dismissal. Within one year after dismissal, the plaintiff would claim the right to refile suit and in the process, buy time to secure the expert testimony it never obtained in the first place.

The Illinois Supreme Court's first attempt to stop plaintiffs from abusing the right to voluntary dismissal occurred in 1986, with the case of *O'Connell* v. *St. Francis Hospital, et al.* In *O'Connell,* the defendant, a physician, did not receive a summons to appear in court until almost nine months after the plaintiff filed the complaint. Citing Supreme Court Rule 103 (b), requiring that a plaintiff not delay unnecessarily in serving a defendant with notice of a lawsuit, the physician's attorneys filed a motion in circuit court to dismiss the suit with prejudice—meaning the plaintiff would not be permitted to refile the suit. In response, the plaintiff filed a motion, which was granted, to voluntarily dismiss the suit.

Two weeks later, however, the plaintiff refiled the suit, and this time, promptly served the defendant physician with notice. Once again, the physician's attorneys moved to dismiss the suit, again citing the plaintiff's failure to comply with Rule 103 (b) in the original action. The circuit court denied the defendant's motion for dismissal.

The physician's attorneys appealed the case to the appellate court and then to the Illinois Supreme Court. The court held that when a plaintiff moves for voluntary dismissal in response to a defendant's Rule 103 (b) motion, the judge must rule on the merits of that motion *before* hearing the plaintiff's motion for voluntary dismissal.

In what is now known as the *O'Connell* rule, the Supreme Court noted that "nothing is more critical to the judicial function" than the prompt administration of justice, and stated that in this case, when the plaintiff voluntarily dismissed its suit, justice was unnecessarily delayed.

For two years after *O'Connell,* defense lawyers tried to expand the rule to include not only Rule 103 (b) but other types of motions as well. Defense lawyers argued that before they hear motions for voluntary dismissal, judges should decide the merits of *all* motions which, if granted, would result in the final dismissal of a lawsuit. Trial and appellate courts, however, refused to expand the rule.

In September 1988, three relevant cases were brought before the Illinois Supreme Court and consolidated for review in *Gibellina* v. *Handley, et al.* In each case, the trial court granted the defendant's motion for summary judgment and denied the plaintiff's motion for voluntary dismissal.

In each case, the appellate court reversed the trial court's ruling, maintaining that the trial court had no choice but to grant the plaintiff's motion for voluntary dismissal before it heard motions from the defense.

The Supreme Court, although affirming the plaintiffs' rights of voluntary dismissal, cited the "noted abusive use of the voluntary dismissal statute," and announced an important new change in the rule. Now, before a plaintiff is allowed to voluntarily dismiss its suit, a trial judge has the power to decide whether or not to hear the defense's motion for summary judgment.

Plaintiffs still have a right to voluntary dismissal, although it is no longer guaranteed. And the Illinois Supreme Court's recent ruling in *Gibellina* v. *Handley, et al.* affirms that from now on defendants' attorneys—and physicians and hospitals—will have another chance to be heard. ▲

George W. Spellmire, Jr., is a partner in the law firm of Hinshaw, Culbertson, Moelmann, Hoban and Fuller, and Ms. Zopff is an associate with the firm. They specialize in legal and medical malpractice defense.

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If these were your patients, how would you have handled these cases?

Case #1

Presenting complaint and initial diagnosis—A 69-year-old man, treated periodically for a duodenal ulcer, saw his physician because his ulcer had begun to bleed. His physician hospitalized him and called in a general surgeon, who immediately operated.

The case in brief—The patient came through the surgery well, but his recovery was slow. He complained of gastrointestinal discomfort and subsequently exhibited signs of infection. He failed to improve significantly over a period of several months, despite administration of antibiotics and a restricted diet.

Eventually, a repeat GI series was performed and exploratory surgery scheduled because of a suspicious mass near the original surgical site. During surgery a sponge which had been left in the patient during the initial surgery was removed and an abscess drained. Recovery was uneventful.

The resulting claim—The patient and his wife sued both the surgeon and the hospital for medical expenses and pain and suffering.

The outcome of the claim—The surgeon argued that the nurses told him the sponge count was correct when the surgery was being concluded. However, a jury awarded the patient $30,000 for pain and suffering and $800 for medical expenses, and awarded his wife $12,000 for loss of companionship, assistance and aid during her husband's illness.

Case #2

The presenting complaint—A 38-year-old construction worker who had been seeing an orthopedic surgeon for continued back pain eventually required a bilateral laminectomy at the L3-L4 interspace.

The case in brief—The surgery was proceeding uneventfully and the surgeon was closing when one of the operating room nurses informed him that a cotton pad was missing. The operating room was searched but the pad was not found. The surgeon reexposed and retracted the nerve root and explored the surgical field to the depth of the intervertebral space, but there was no sign of

(continued on page 7)

Case in point

(continued from page 6)

the pad. A portable x-ray machine was brought in, films were taken, but neither the surgeon nor the radiologist saw the pad in the films. The surgery was concluded and the steps taken after the cotton pad was reported missing were recorded in the chart. Five days following surgery, the surgeon noted some puffiness under the incision and ordered repeat x-rays. These films disclosed the presence of the foreign body which apparently had slipped under the bony area at the site of the laminectomy. The surgeon informed the patient. Two days later, a hematoma was evacuated from beneath the incision and the epidural space was reentered to remove the cotton pad from atop one of the L-4 nerve roots. The surgeon noted in the record that there was no evidence of inflammation or other damage as a result of the presence of the pad in the epidural space for seven days. The patient was discharged after a 13-day hospital stay. He returned several times during the next year, complaining of increasing back pain. Eighteen months later, the man sought care from other physicians and shortly thereafter, an additional laminectomy at L5-S1 was performed.

The resulting complaint—The patient sued, alleging that a foreign body left in the laminectomy site led to recurrent back and leg problems and necessitated additional surgery. He claimed that all medical expenses following the first laminectomy and expenses from the surgical procedure to remove the cotton pad resulted from the retained foreign body.

The outcome of the claim—All consultants reviewing the claim agreed that the cotton pad left for a brief period in the epidural space did not cause the patient's subsequent additional back problems and that the surgeon had made every attempt to detect the presence of a foreign body and had then removed it when it subsequently was found on a second set of x-rays. However, a modest settlement was negotiated because the foreign body did extend the patient's hospital stay and contributed to several days of additional pain and suffering.

The points these cases make—Suits still arise from foreign bodies left in a patient's body after surgery. There may always be such occasional claims. Consultants stress that the possibility of leaving behind a sponge, needle or instrument is always present and that is why operating room counts and specific procedures for ascertaining that counts are accurate and discrepancies are immediately reported and followed up on are essential.

In the first case described, the surgeon's defense was that the nurses informed him that the instrument and sponge counts were correct as he was closing. While the hospital may assume the larger share of liability when nurses tell a physician that a count is correct when it is not, liability also will accrue—sometimes 50 percent or more—to the doctor. The fact that proper procedures for counting were followed and that the discrepancy occurred in spite of precautions taken will be considered in defense. In earlier days, the absence of counts showed that no precautions were taken to account for instruments, needles and sponges used on the patient during surgery. These cases were indefensible.

In the second case described, when informed that a pad was missing, the surgeon pursued every reasonable course available to find it, even though he failed to do so. This was a strong argument in his defense.

Here are the steps consultants say should be taken to minimize the chances that a foreign body will be left in a patient:

- —Always ask nurses about instrument and sponge counts as a procedure is being completed.
- —Do a visual search at closing even when counts are said to be correct.
- —If a nurse reports an item missing, the team should search the operating room carefully.
- —Recheck the incision site if possible, if the patient's condition will not be jeopardized by the delay.
- —Call for a portable x-ray and check films quickly before final closing if possible.
- —If it appears there is a possibility that a foreign object has been left in the patient, factually note the information and what actions were taken to try to find the object in the chart.
- —If the patient's condition does not permit the time for x-ray confirmation prior to closing, order an x-ray during the patient's hospital stay to see if the foreign object is present.
- —Observe the patient carefully postoperatively for any signs that a problem may be developing that is a result of the possible retained foreign object.
- —If a problem is developing, move to correct the situation as quickly as possible.

Should a patient be informed that a foreign object may have been left in the body, even when chances are remote that it will cause later difficulties? Yes, say consultants. Such a patient should be told the truth and advised about what to look for that could indicate that problems are developing. Failure to disclose the information could provide grounds for a later suit and will also extend the statute of limitations as it relates to discovery of the injury. ▲

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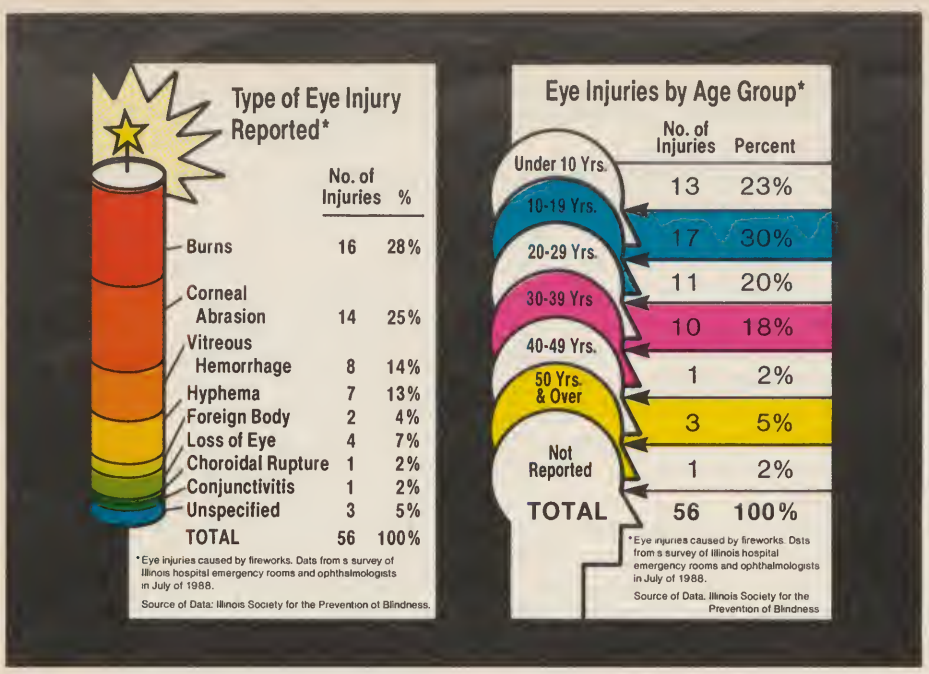
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J6VS18R



Coalition asks MDs to emphasize prevention of fireworks injuries

AS THE NATION gears up for the Fourth of July celebration, a coalition of health care and safety organizations coordinated by the Illinois Society for the Prevention of Blindness (ISPB) is calling upon physicians statewide to get involved in an all out effort to heighten public awareness of firework danger.

Because fireworks in Illinois are illegal to the general public and, according to ISPB, there is a better understanding of their hazards, injuries this year are expected to decrease. However, physicians warn that many children and adults using firework related products will still spend the holiday in hospital emergency rooms.

Bernard Gawne, M.D., president of the Illinois Association of Ophthalmology (IAO) stresses the need for physicians to help out locally by advising patients and encouraging others not to use fireworks. "Physicians need to stress prevention of injury. Once people are hurt, they may require extended health care."

Statewide study reported

According to a statewide study by the Office of the State Fire Marshal, 350 people were injured by fireworks or firework-related incidents during a four week time period last year that included the July 4 holiday. The study reflects the experience of 120 hospitals responding, out of a total of about 250 surveyed. Fourteen percent of the hospitals saw no firework related injuries. Males accounted for 47 percent of the injuries while 20 percent of those hurt were females. Thirty-three percent were not identified by gender.

For the third consecutive year, hands and fingers topped the list of the most common injuries. Eye injuries were next in line, followed by head and face injuries. Damage to legs, arms and feet neared the bottom of the list. Types of injuries patients sustained from using fireworks included burns, lacerations, abrasions and fractures.

Clyde Smoot, M.D., assistant professor and plastic surgeon at Southern Illinois University School of Medicine warns children should be kept away from fireworks even when supervised by adults. "We've had children that have blown off most of their fingers with the more powerful items such as cherry bombs. Also, clothes can catch on fire causing severe burn injuries." Recalling an incident when a cherry bomb exploded in a young boy's pocket, Dr. Smoot said, "the boy required extensive skin grafting and dermabrasion to rid himself of extensive powder burns suffered along the groin area."

Eye injuries a major problem

"While skin grafting is generally successful in smoothing out skin surfaces," Dr. Smoot warns, "the procedure can be a problem on parts of the face, particularly eyelids where skin is especially thin." According to an ISPB survey of nearly 1,000 ophthalmologists and hospital emergency rooms in the state, one of every three firework injuries is to the eyes while one of every four firework eye injuries results in some kind of permanent blindness. "Last year, four males in Illinois lost an eye to firework accidents," says James McKechnie, ISPB executive director. He added, "One cannot put a price tag on a precious commodity such as the value of eye sight that is often too easily injured from the use of fireworks."

Physicians agree eyes are most vulnerable to damage from firework explosions because they're not well protected. In an effort to enhance firework public awareness, the IAO

(continued on page 9)

VASOTEC®
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Contraindications: VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient caretully observed until the swelling disappears. In instances where swelling has been contined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, buf discontinuation ot therapy tor continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See OOSAGE AND AOMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and AOVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial intarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses ot VASOTEC, which usually can be given withouf ditficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation ot enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the tirst few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation ot therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, it at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. It hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially tollowing the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned fo report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to reporf promptly any indication of infection (e.g., sore throat, tever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This intormation is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction ot blood pressure atfer initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose tor at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and OOSAGE ANO ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence ot clinically signiticant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Theretore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored trequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses ot 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was tound to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies in pregnant women. VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justities the potential risk to the fetus.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Satety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated tor safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 298/ patients.

Hypertension: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

Heart Failure: The most trequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% ot patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial intarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dystunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION), prostate hypertrophy.

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% ot patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hyperfensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% ot patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% ot patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations ot liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, it possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) It the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized tor at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. It blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases ot serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day ot VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Oosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See OOSAGE ANO AOMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration ot renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD representative or see Prescribing Information. Merck Sharp & Dohme, Division ol Merck & Co., Inc., West Point, PA 19486. J6VS18R(815)

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Fireworks

(continued from page 8)

has sponsored a public service announcement (PSA) alerting people to the dangers of fireworks. Last year, the PSA was viewed by more than 200 million people nationwide. Dr. Gawne says he hopes the message will reach more people this year. ISPB will also be distributing thousands of flyers and posters to public schools, state libraries and park districts statewide as part of its public awareness campaign on firework dangers.

"I have also seen adults who have lighted firecrackers in pipe-like containers. When it doesn't explode, they stick their faces near the pipe to see what the problem is. It ends up exploding in their face, causing serious injuries to the eyes," says Dr. Gawne.

"Ophthalmologists should be consulted even in minor eye injuries. Damage may not be obvious by examining the exterior of the eye in certain injury cases seen in hospital emergency rooms," adds Ronald C. May, M.D., an IAO past president.

Lance P. Steahly, M.D., professor and chairman of the department of ophthalmology at Southern Illinois University says "most likely, only a severe injury such as an explosion in the face can actually cause the eye to be ruptured. However, physicians may see other damage resulting from particles of an explosion entering the eye. This can result in the development of a cataract or regional tears or holes in the eye which can be permanent. Physicians will more typically see scratches in the cornea caused from firecracker deposits under the eyelid." ▲

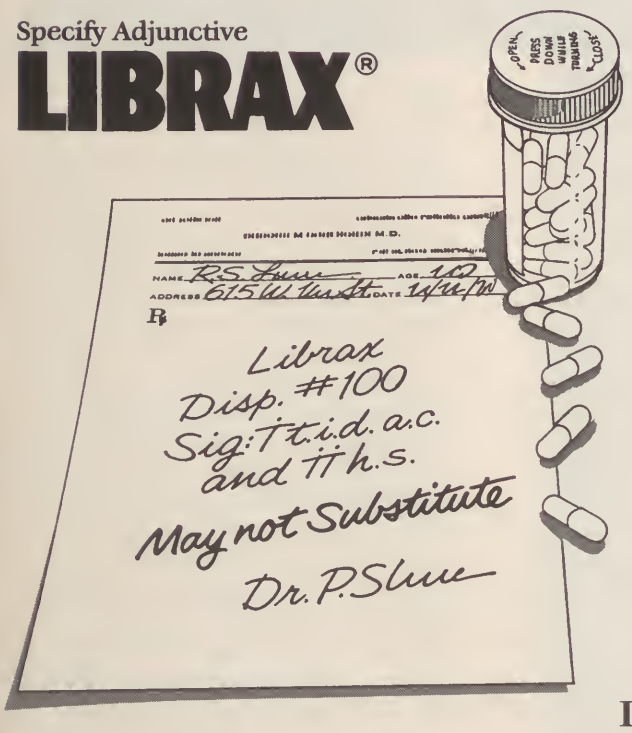
Legalizing "class C" fireworks defeated

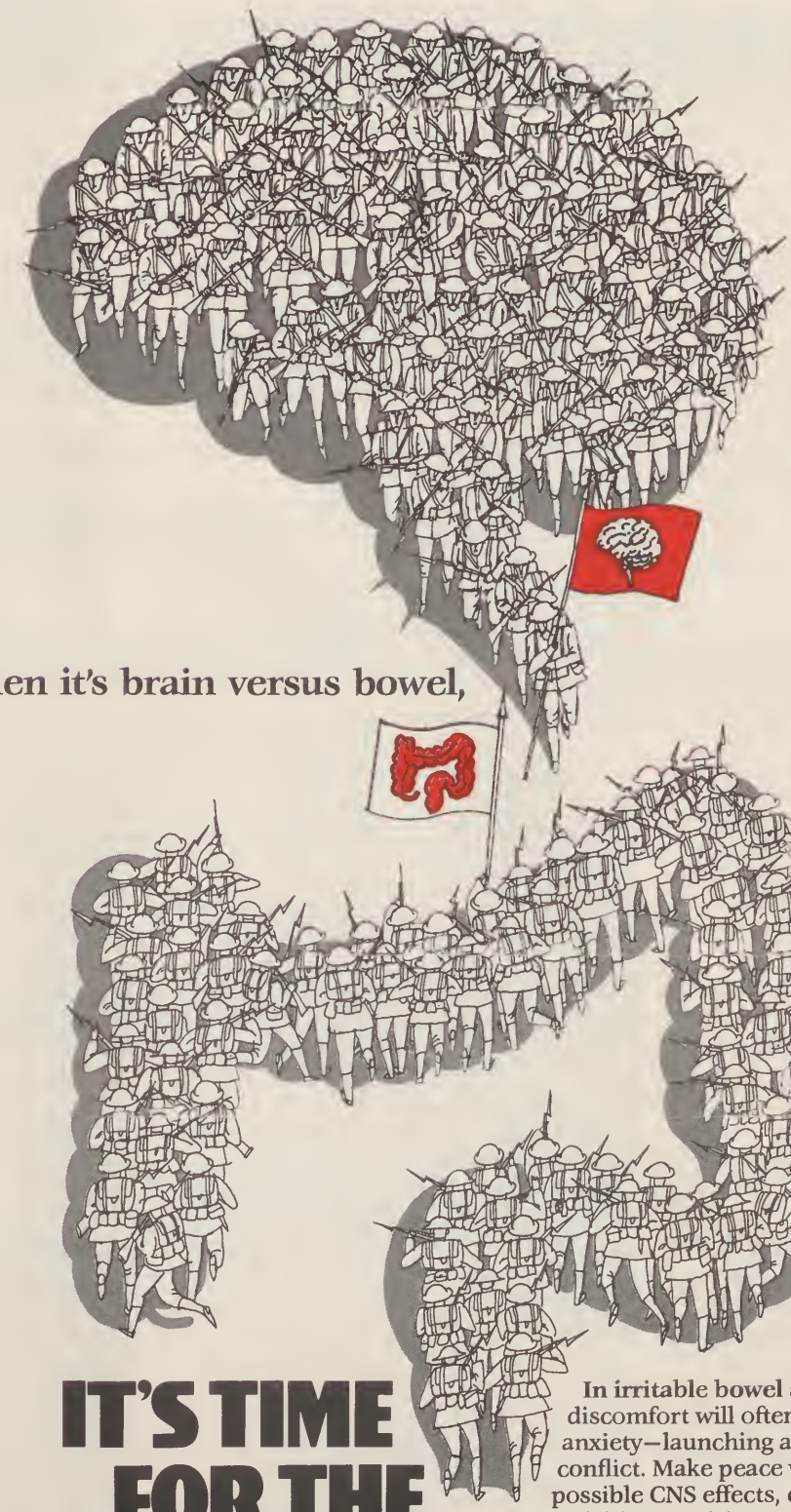
Legislation banning the use of sparklers, sponsored by Rep. Karen Hasara (R-Springfield), and making the sale of "class C" fireworks legal, sponsored by Rep. Mike Tate (R-Shelbyville), was defeated in the Illinois House earlier this session.

H.B. 2339 would have allowed adults over the age of 21 to buy fireworks for about three weeks in June and July. "There's a huge black market in Illinois where fireworks are being sold illegally. It's my hope people who buy fireworks in Tennessee or Missouri would instead purchase them here because projected revenue from these sales would be in the millions," said Tate. "The bill also would have required a license to shoot the fireworks off. It's a 'catch 22' situation, but these funds would be given to the state fire marshall's office to help them properly enforce the use of fireworks," he added.

Yet another measure to prohibit the sale of fireworks at wholesale cost except in cases of supervised public displays has been sent to the Senate after passage in the House. H.B. 576 is sponsored by Rep. Linda Williamson (R-Franklin Park) and Senator Robert Raica (R-Chicago). ▲

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In IBS,* when it's brain versus bowel,

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In irritable bowel syndrome,* intestinal discomfort will often erupt in tandem with anxiety—launching a cycle of brain/bowel conflict. Make peace with Librax. Because of possible CNS effects, caution patients about activities requiring complete mental alertness.

*Librax has been evaluated as possibly effective as adjunctive therapy in the treatment of peptic ulcer and IBS.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

P.I. 0288

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Physicians can play key roles in helping child abuse victims

by Tina Panoplos

PHYSICAL and sexual abuse admittedly aren't easy to diagnose, but physicians need only suspect abuse—not prove it—to get help for children.

Illinois law requires that physicians file a report with the Illinois Department of Children and Family Services (DCFS) when they suspect abuse.

"They just need to suspect it, they don't have to conduct their own investigations," noted Tom Teague, DCFS spokesman.

Physicians who fail to report abuse can face medical licensure discipline.

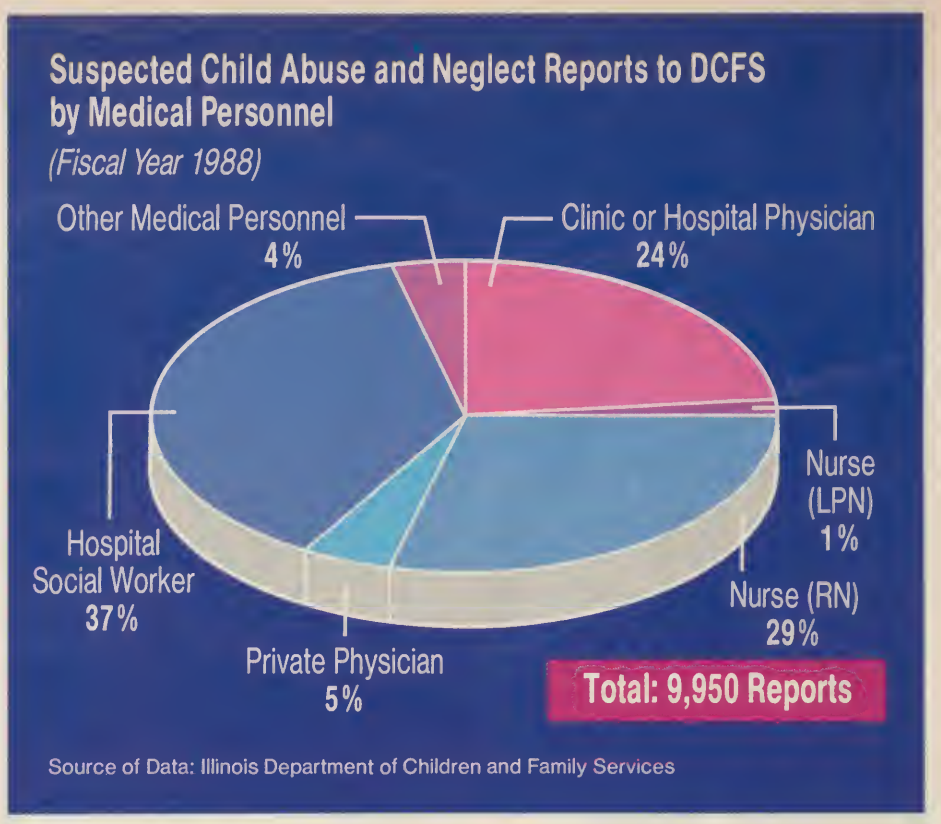
In fiscal year 1987, the last year for which figures are available, the DCFS received 91,723 reports of children believed to have been abused or neglected. Of the 39,006 children for whom the DCFS found "credible evidence" of abuse or neglect, 75 percent were abused or neglected by their natural parents.

In addition, of the more than 90,000 reports made in fiscal year 1987, 8,518 came from physicians or other medical personnel.

Physicians who have questions about whether a certain injury might be a sign of abuse can contact the DCFS hotline to talk to a medical consultant. Teague noted that physicians also can call the hotline to find out if there have been past reports of abuse involving a particular child.



Illustration by Ken Simpson



Dealing with parents

Stephen Sheldon, D.O., chairman of the Illinois State Medical Society (ISMS) Subcommittee on Child Abuse Education, said that in most cases, physicians should tell parents when they make a report to the DCFS. "This can be done in a very supportive way," he said. Dr. Sheldon suggested that physicians tell parents that DCFS is being contacted about a child's injury because the physician needs help sorting out how the child's injury occurred.

Physicians should be honest with parents, and tell them what is going to happen once the report is made, she added.

Paula Jaudes, M.D., associate professor of pediatrics at the University of Chicago and medical director of the child abuse and neglect program at La Rabida Children's Hospital and Research Center, agreed that physicians should take a nonaccusatory approach when talking to parents.

"I usually say, 'I don't know how Johnny got his broken arm.' . . . I don't say, 'I think he's been abused,' because I don't know that," said Dr. Jaudes.

There are some cases in which physicians should contact DCFS before they talk to a child's parents, according to an ISMS report, "Child Abuse and Neglect: The Physician's Role."

"In cases of severe physical or sexual abuse and where there is a danger of the parents disappearing with the child," the publication stated, "the department should be contacted *before* you inform the parents of your suspected diagnosis. Above all, remember that the primary concern is to protect the child."

Teague pointed out that physicians do not have to tell the parents that they are making a report to the DCFS.

"The law does not require that parents know who the reporter is," Teague said. He added, "I can understand why doctors would tell parents, but they don't have to."

Physicians who report a case of suspected abuse in good faith also are protected by the law from civil suits involving the case. In addition, in cases of abuse where a physician feels that letting a child stay with his parents or guardians poses a significant risk to the child's life or health, a physician can take protective custody of the child. Physicians who do so, however, must inform the DCFS immediately.

Howard Levy, M.D., the director of the pediatric ecology unit at Mt. Sinai Hospital and Medical Center in Chicago, which cares for abused children, said that if physicians have to "bend over backwards" to believe an explanation of how a child's injury occurred, then they should suspect abuse.

Some symptoms of abuse

Some conditions that might indicate abuse include spinal fractures, bruises or fractures in different stages of healing, or bruises in areas such as the ears, mouth, eye, back, buttocks, torso or genitals. Adult human bite marks, cigarette burns and failure to thrive also can be signs of abuse or neglect.

Dr. Levy pointed out, though, that signs of physical and sexual abuse take many forms. There is no "litmus test" for diagnosing abuse, he said.

Talking to a child in a developmentally appropriate way, undressing the child and doing a complete physical exam, and keeping an open mind are all steps physicians can take to help them diagnose abuse, Dr. Levy said.

A delay in seeking treatment for a child's injury also could signal abuse, said Demetra Soter, M.D., attending physician in pediatric critical care and coordinator of the pediatric trauma center at Cook County Hospital. Dr. Soter said that she always orders x-rays on children when she suspects abuse. She also asks to see the child's siblings.

When telling parents that she is reporting a child's injury to DCFS, Dr. Soter might say that she has to report any cases where a child has such a serious injury. If she feels a child is at risk for further abuse, she waits until the child has been admitted to the hospital before telling the parents she is making a report. Sometimes, she said, it helps to make the law the "bad guy." She'll tell parents that she's sorry she has to make the report, but it's the law.

(continued on page 13)

Lawmakers push to link drug abuse, child neglect

Efforts to keep drug-abusing women from becoming child-abusing parents have moved to the legislative arena in Illinois where concern is growing over the number of infants born chemically dependent.

The Illinois Department of Children and Family Services (DCFS) received 181 reports of drug-addicted infants statewide in its 1985 fiscal year, which ended June 30, 1985. In fiscal year 1988, that number had climbed to 1,234 infants. During the first nine months of fiscal year 1989, DCFS received 1,627 reports of infants born chemically dependent in Illinois. The majority of reports came from Cook County and involved cocaine, according to DCFS spokesman David Schneidman.

DCFS recently joined DuPage County state's attorney James Ryan in urging passage of legislation which provides that if newborns have any controlled substance in their system, they automatically classify as "neglected children" under the Juvenile Court Act. That bill, and several other related measures are under consideration by the state legislature.

Among them, S.B. 613, sponsored by Senator Earlean Collins (D-Chicago) and introduced by Rep. Lovana Jones (D-Chicago) in the House, would amend the Abused and Neglected Child Reporting Act. The bill provides that any newborn infant who is physically dependent on a controlled substance is an abused minor. The bill also requires providers, including physicians, to refer all addicted pregnant women to the Illinois Department of Health for assistance and counseling, and requires IDPH to create a program of residential treatment and counseling for prenatal care and care of an addicted mother and child in areas where a disproportionate number of addicted infants are born. Another measure, S.B. 1413, sponsored by Senator Margaret Smith (D-Chicago), requires physicians currently reporting under the Abused and Neglected Child Reporting Act to report pregnant addicted women as abusers to IDPH and a local substance abuse treatment provider for treatment.

Ira Chasnoff, M.D., director of the perinatal center for chemical dependency at Northwestern Memorial Hospital and a nationally-known expert in the field, favors the pending legislation that allows legal intervention for newborns whose urine tests positive for controlled substances, but who are asymptomatic. Under current law, he explained, authorities cannot intervene unless the baby shows symptoms of drug withdrawal. "As a result, a lot of babies are falling through the cracks," he said.

Dr. Chasnoff opposes legislation requiring physicians to report addicted pregnant women, since it would discourage addicted expectant mothers from seeking pre-natal care, he commented. As one way of improving substance abuse diagnosis and treatment, he advocated increased education programs for physicians, since "most physicians aren't comfortable with treating drug abuse, and don't know how to take a drug abuse history."

Studies have shown that women who are drug-dependent are more likely to abuse their children, said Dr. Chasnoff.

The risk of abuse can be even higher when a drug-dependent woman has a drug-dependent baby.

Gerald Staub, M.D., medical director of the pediatric intensive care unit at Swedish American Hospital in Rockford, said it's important early on for physicians to detect if a woman has a drug-use problem. Women who use cocaine during all three trimesters of pregnancy have a much higher incidence of premature births, are more likely to have infants who are small for gestational age, have twice the incidence of ruptured placenta and have a low birthweight rate, Dr. Staub said.

Children learn to protect themselves

Children in Danville, Illinois, are learning to protect themselves from becoming victims of abuse through a program spearheaded by the Vermilion County Chapter of the Illinois State Medical Society Auxiliary.

Through the use of curriculum guides and videotapes purchased by the auxiliary, teachers in Danville School District 118 have incorporated a personal safety training prevention program into their lesson plans.

"It's the sort of program you might not know the effects of for ten years," said Cheryl Vergin, president of the Vermilion Auxiliary.

Vergin said that since the program began, there have been two cases that have resulted in reports of abuse. In another incident, Vergin said that a man approached a group of children and wanted them to go with him in his car. The children yelled, "No!" and ran back to the school to get help. The children said they did that because that's what they had learned to do in school.

Denise Halloran, workshop instructor who has a masters degree in counseling, first saw the personal safety program being used at a preschool in Seattle. She received training from the developers of the program, the Seattle Institute for Child Advocacy, so that she could train teachers to use the program.

In 1986, the first year of the program, 12 teachers from the district completed the program.

In the initial year of the program, the Vermilion Auxiliary raised $5,400 to pay for curriculum guides plus a set of three videotapes. The auxiliary raised the money through auctions and through an international cuisine dinner. Since then, the auxiliary has continued with fundraising efforts to raise money to purchase additional curriculum guides for teachers in the school district.

All of the district's school principals have received training in the program along with at least one teacher from each school who acts as a resource for the others. In addition, all new teachers now are required to watch a four-hour training tape on the program.

Halloran, who now serves as a consultant for the school district's social health programs, said the curriculum guides for the program are easy to use and don't require teachers to do a lot of planning.

"It doesn't require a lot of time on their part," she said.

Vergin said the curriculum guides cost about $50 each, while a set of three videotapes also prepared by the Seattle Institute for Child Advocacy costs $200 per tape. ▲

The issue of cocaine babies came further into the spotlight recently with a highly-publicized and controversial case. Melanie Green of Rockford was charged with involuntary manslaughter when the death of her 2-day-old daughter, Bianca, born February 2, was attributed to the woman's use of cocaine during pregnancy.

Although the charges against Green were subsequently dropped, P. John Seward, M.D., Winnebago County coroner, said the case raises the question of how far such charges could go. Does it make a difference whether the drug a woman abused during pregnancy was an illicit drug, such as cocaine, or a drug such as alcohol?

"I guess I would submit that from a medical standpoint it doesn't matter," Dr. Seward said.

Critics of the charges brought against Green have argued that the interpretation of the law in that case violates the right to privacy. Others have said that it doesn't get to the root of the problem—getting treatment for the substance-abuser.

"What is needed is to make physicians and hospitals aware of those things to look for when treating women who might be cocaine users," Schneidman said.

Dr. Seward said that having appropriate drug treatment centers could help lessen the problem. Right now, he said, there aren't enough centers for the people who need them.

Dr. Staub believes the way to solve this problem of drug abuse, and reduce the number of babies born drug-dependent, is through education.

"I think it has to start with education of the public as a whole," said Dr. Staub, "especially women of child-bearing age."

Dr. Staub said the legal approach to discouraging women from using drugs while they're pregnant will most likely have the opposite effect. Accusing pregnant women who use cocaine or other illicit drugs with prenatal abuse, however, could have some effect on physicians.

"It would broaden the guidelines upon which they would have to make a report, but it wouldn't do anything to change maternal behavior," Dr. Staub said. ▲

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Brief Summary
Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.
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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.
3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.
Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.
Drug Interactions – No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.
Carcinogenesis, Mutagenesis, Impairment of Fertility – A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.
Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.
In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.
Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers – Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.
Pediatric Use – Safety and effectiveness in children have not been established.
Use in Elderly Patients – Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.
Hepatic – Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.
Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.
CNS – Rare cases of reversible mental confusion have been reported.
Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.
Hematologic – Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.
Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.
Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.
Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.
Signs and Symptoms – There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.
Treatment – To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.
If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.



Joseph Kremper, M.D.

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(continued from page 10)

The physician and the child

When children tell physicians that they have been physically or sexually abused, it's important for physicians to emphasize that they believe the children, said Dr. Jaudes. While Dr. Jaudes said that some of the stories physicians might hear can be "horrifying," she stressed that it's important that physicians don't react to the story. Instead, physicians should tell the children how brave they are for telling them this and assure the children that they did the right thing. Dr. Jaudes said that physicians should not promise a child things they can't do.

"Physicians cannot promise [a child] that everything will be all right," Dr. Jaudes said. They can, however, promise to protect the child as much as possible.

Dr. Levy brought out another point.

"The fact that there are not physical findings doesn't mean that the event didn't happen to the child," Dr. Levy said. He acknowledged that some people might contend that children do lie sometimes. "If a child tells you something, that doesn't mean you have to believe it," he said, "but you can't dismiss it out of hand." He added, "Kids can't make up what they haven't been told or exposed to."

Physicians can take steps toward preventing child abuse by taking note of parents who are at risk for committing abuse and getting them into parenting classes. Dr. Jaudes said poor interaction between a child and parent or a parent who has unrealistic expectations for a child can fall into this risk group.

When physicians suspect abuse has occurred, however, Dr. Soter cautioned physicians and others against taking it upon themselves to refer families to services on their own. When they do that, she said, there's no record of the abuse anywhere.

Dr. Soter suggested that once physicians report abuse to DCFS that they find out who the investigator is for the case. If the investigator determines that a report is "founded" (they feel they have enough evidence to pursue the case) then physicians should find out who the follow-up worker is.

"Sometimes kids can get lost between the investigation and the follow-up," she said.

Rep. Michael Curran (D-Springfield) has introduced legislation that would lower the case load on caseworkers and investigators of child abuse and neglect reports. Sometimes workers are handling as many as 70 to 80 cases, he said. He'd like to see that lowered to 25-30.

The amount of paperwork involved in doing 50 cases is a full week's worth of work in and of itself, according to Curran.

"It makes it literally impossible for them to do a good job," he said.

But Dr. Soter noted, "Even with the problems in the system, you really owe it to the kid to report (suspected abuse)."

For additional information on diagnosing and reporting child abuse, consult the ISMS publication, "Child Abuse and Neglect: The Physician's Role." ▲

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Members of the Jesse White Tumbling Team and Dance Troupe practicing in Cabrini-Green, one of Chicago's toughest and poorest neighborhoods.

Rep. Jesse White: A good friend to Illinois' youth

IT'S MONDAY at four-thirty in the afternoon and State Representative Jesse White (D-Chicago) from the eighth district, still has a full day's work ahead of him. In preparation for his one day in Chicago, the legislator has been up since early dawn. He spends the rest of the week in Springfield.

Now, at his busy Chicago headquarters at 1452 N. Sedgewick Ave., where more than 60 awards line the walls of his office . . . "with gratitude" . . . "for outstanding dedicated service" . . . "in appreciation of his generous contributions" . . . he moves quickly about noting, "Never enough time, never enough time." He finishes one phone conversation, then carries into another room four donated bags of clothes for a drive he's organized. While a group of young black children play in and out of his office, White forthrightly assures one teen-age boy that he will discuss the child's problem in length later that day.



Representative Jesse White (D-Chicago)

Reviewing the troupe

Forty-five minutes pass. White enters an old run-down building in the Cabrini-Green public housing project on Chicago's near north side, one of the city's roughest and poorest neighborhoods. He and several members of the internationally famed Jesse White Tumbling Team and Dance Troupe, dressed in red uniforms with white suspenders, are ready for practice here. All of the team members reside in or around the neighborhood.

Explaining the "van routine," White signals the boys outside onto a field. "I'm going to pull the van up near the mats and they will zip over the van," he adds. His eyes are glued on 19-year-old Tydell McNeal, a 12-year team member. McNeal takes a running start, bounces off a minitramp and dives gracefully into the air. White shouts, "Let's go Tydell, stretch out, look straight ahead." The boy goes over the van, into a somersault and is back on the ground in seconds.

Since the troupe's beginning, White is credited with bringing new hope and prominence to 885 once oppressed and troublesome young people who've tumbled their way through the program and around the world over the last 30 years.

"He's like a father to me, if it weren't for him, I'd probably be on the streets. He keeps us out of trouble, teaches us to say no to drugs and tells us to stay in school and be somebody," says McNeal.

> *In the eyes of his legislative peers, he is recognized as a man who . . . gives freely of himself, cares about the issues, listens to all sides and doesn't pre-judge.*

"He teaches us how to dress properly, what to say, what not to say and the best way to say it, little habits you wouldn't find at home because you only have one parent," adds 21-year-old Terrence Smith who's worked with White for 11 years.

After practice, the team gathers around a table inside. "You guys did a beautiful job. Sam, your fly was fine . . . really liked it . . . Ticky, next time make sure you come properly prepared to take care of the business of the day, you understand that? Couple of things about the schedule now. On Wednesday, meet at the office because we're doing half time for the Bulls game. The following day, we'll appear on the David Letterman show. The ones to be selected for this must appear at 1:00 p.m. in the office. The other gentlemen must appear at 2:00 p.m. because they will perform at Northeastern . . . "

The journey to prominence

Born in Alton, Illinois, White's family moved to Chicago when he was four and settled on the near north side. He attended Schiller Elementary School, then Waller High School where he was all-city in baseball and basketball. In 1953, he won an athletic scholarship to Alabama State University in Montgomery. He earned his degree in physical education and for three years was all-conference in baseball and basketball at just 5'9". After two years in the army, he returned to Chicago and taught school at Schiller Elementary during the day while working for the park district at night. There he was asked to put a tumbling show together and that's how the team got its start. Today, White remains the team's non-salaried director and personally covers for any year-end deficits the group incurs.

White is serving his thirteenth year in the Illinois General Assembly and chairs the Human Services Committee which controls nearly a third of the state's budget in public health and social programs. He says, "I was drafted to the position. I was asked back in 1973 to run for office to replace the retiring state representative and I said no, no, no, hell no, for a long time . . . nine months. Finally, I gave in and ran."

In the eyes of his legislative peers, he is recognized as a man who, as Rep. Peg McDonnell Breslin (D-Ottawa) describes, "gives freely of himself, cares about the issues, listens to all sides and doesn't pre-judge."

Committed to quality health care

White points out that his priorities include maintaining the quality health care that is "so vitally necessary in the state of Illinois." He adds, "It's up to me not only to be fair in my chairmanship role, but also to make sure that my party, which is committed to good quality health care, doesn't let a bill get passed out of committee that is not in the best interest of the people I speak for."

White holds steady in his commitment to the medical profession. As for ISMS-backed tort reform legislation he says that, "if and when that fight occurs again, I want the medical profession to know I'm with the doctors and not the lawyers. That's the time you have to pick and choose, and know just who your friends are."

"One word describes Jesse White as a legislator and person—outstanding. He's one of a kind and my hero," says Rep. Charles G. Morrow III (D-Chicago).

Sixteen-year-old Chester Brewer sits at the table staring out the window onto the practice field where for seven years White equipped him with hope. "I want to be a physical education teacher and run a gym room or work in a park district. Jesse's made me proud of myself and where I come from." ▲

Exclusive contracts a growing dilemma for Illinois physicians

by Eileen Norris

AN ILLINOIS MEDICINE SPECIAL REPORT
Exclusive Contracts

EXCLUSIVE CONTRACTING arrangements between hospitals and groups of medical specialists are not new. Such agreements, which have been upheld as perfectly legal by the courts, are commonplace in hospital radiology, pathology, and anesthesiology departments—and have been for years.

But now, in a handful of cases, these exclusive contracts are making their way to the cardiac surgery departments at suburban community hospitals, which are hiring widely-known medical schools to run their programs.

Some cardiovascular surgeons who have had privileges at those suburban hospitals to perform cardiac procedures in the past say their practices have been all but frozen out of the picture by these exclusive arrangements.

Physicians fear that as community hospitals continue to aggressively market "high-ticket" procedures with "brand-name" medical schools, the contracting arrangement may spread to even more medical specialties in the future.

"The average physician is very concerned about these arrangements," says Raymond Dieter, Jr., M.D., a thoracic surgeon and trustee of the Illinois State Medical Society.

"Most physicians don't like the concept, and hope it's not the wave of the future," he adds.

Is med school affiliation at issue?

A hospital that wants to start an open heart surgery program, for example, must make a "certificate of need" application with the Illinois Health Facilities Planning Board (IHFPB) in Springfield. The board reviews the request against the state's extensive criteria, including the need for such a program and if it would be appropriately staffed, and either approves or denies the request.

When Good Samaritan Hospital in Downers Grove was given the go-ahead three years ago by the state to begin a cardiac surgery service under the auspices of Loyola University's Stritch School of Medicine, Raj B. Lal, M.D., says he lost a good chunk of his business.

"When this exclusive contract was awarded to a group of surgeons affiliated with Loyola, all of the cardiovascular surgeons who had privileges at Good Samaritan were deprived of doing cardiac procedures at this hospital," says Dr. Lal, who had been a cardiovascular and thoracic surgeon at Good Samaritan since 1976. "Luckily, I'm on staff at different hospitals, but I used to be the busiest cardiac surgeon at Good Sam and then my practice there just disappeared."

Dr. Lal says he and other physicians were under the impression that a hospital proposing an open heart surgery or cardiac catheterization program had to have a medical or teaching hospital affiliation to get a certificate of need approved from the state.

But that medical school affiliation requirement was dropped more than four years ago, says Bill Ewing, a health planner at the IHFPB. He said only non-kidney organ transplants require a university affiliation for certificate of need approval.

Furthermore, he said of the 250 applications the planning board gets every year from hospitals and institutions wanting to start new programs or departments, most do not have a medical school affiliation.

"We can't tell hospitals what surgeons to use, and we don't look for agreements between hospitals and whomever they want to be affiliated with," adds Ewing.

Good Samaritan's associate administrator John Bruss defends the use of exclusive contracts.

"We have to maintain a standard and quality that would be tough to do if we had different surgical groups using different approaches and different equipment," he says.

But that "standard of care" issue doesn't wash with Dr. Dieter. "I don't believe that makes any difference because everything else done in a hospital is done by different physicians and the results are comparable," he argues.

Contracts and patient choice

Loyola Hospital director Robert Condry says he can understand both sides of the argument for and against the use of exclusive contracts. Loyola provides cardiac surgery teams through an exclusive contract not only with Good Samaritan but also with Hinsdale Hospital. Alexian Brothers in Elk Grove Village, which has not yet begun its open heart surgery program, also has an exclusive contract with Loyola's cardiac surgery team.

Condry maintains the arrangements don't restrict patient choice, a criticism made by Aladin M. Mariano, M.D., a cardiovascular surgeon at Alexian Brothers. "The crux of the issue is freedom and the exclusive contract takes away the freedom of the physician to practice and it takes away the freedom of choice from the patient," says Dr. Mariano.

"Certainly, any institution has the right to enter into an agreement with whomever it wants, but in this case it violates common decency. I would appeal to their sense of justice and fair play," he says.

But Condry of Loyola says patient choice shouldn't be affected by exclusive contracts. "Most cardiac care patients are referred by their primary care physician and if a referral is made to a certain group, it's made for a reason," he says.

"For the same reason you go to the store and buy one suit over another, you do so because you believe you're getting a higher quality. It's not purely dollar driven and neither is medicine."

Secondly, he said, most patients undergoing heart surgery get a second opinion before having an operation, so a hospital's exclusive contract shouldn't have any effect on physician choice.



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Aladin M. Mariano, M.D.

A new competitive tool

And Condry says physicians who may lose privileges to perform certain procedures at a hospital with an exclusive contract shouldn't have any trouble finding other opportunities, especially in cardiac surgery, within the Chicago area. "More programs are sprouting up and the opportunities are multiplying," he says.

Community hospitals are linking up with medical schools so that they can offer patients quality and performance, adds Condry. But Bruss of Good Samaritan Hospital says that although a prestigious affiliation is used as a marketing tool, a relationship with a teaching hospital is really a two-way street.

"It's not just the community hospital that benefits, but the teaching hospital gets experience for its resident physicians as well," he says.

That "advantage" doesn't strike a sympathetic cord with physicians who worry that these contracting arrangements could mushroom and find their way to other specialties. "The medical climate is such that this could grow to other fields," says Dr. Lal. "And if that happens, then the flame will become so intense it will engulf all of us."

At a time when hospitals are losing patients to out-patient services, institutions are looking for other ways to keep their hospital beds occupied, maintains Dr. Dieter. "They don't want to lose their local patients, especially on these 'high-ticket' procedures that bring in revenue," he says.

"If this trend continues," adds Dr. Mariano, "literally everyone will be affected. My main gripe is that exclusive contracts are an infringement on the right of others. It prevents competition and it's unfair.

"If the argument is quality, these cardiovascular surgeons are already providing quality care to open-heart surgery patients. They are certified by the board of surgery, and have the necessary experience and training. So the issue isn't quality—it's competition. The question is—can anyone restrain trade under the guise of quality?" ▲

Where physicians can turn for help

Physicians who face being edged out of performing a particular medical procedure because of an exclusive contract between a hospital and a medical group can log a complaint with the state.

Every hospital that wants to add a service or department must get a "certificate of need" approval from the Illinois Health Facilities Planning Board, (IHFPB) the state body charged with reviewing and granting such requests.

Physicians can request that the planning board hold a public hearing to discuss a hospital's certificate of need application. Or they can write to Ray Passerie, the executive secretary of the IHFPB at 535 W. Jefferson in Springfield, IL, 62761.

But the IHFPB says it has no jurisdiction over exclusive contract agreements between hospital and physician groups. Still, it welcomes information and/or letters of concern from physicians.

Board certified and qualified doctors can also apply for and be granted special privileges at the university hospital running a program for a community hospital, says Robert Condry, director of Loyola's Foster G. McGaw Hospital. "We may have an exclusive contract to provide a service, but it's not restrictive as to who applies for privileges," he says.

That may be true, but one physician, who didn't want to be named, said that when it comes to exclusive contracts, applying for privileges and getting them are two different things. "You might get approved, but you won't be able to perform the procedure until after the exclusive contract runs out and that may be 10 years away."

Illinois courts have held that granting hospital privileges is a local issue determined by each hospital in accordance with its bylaws.

"It appears that as long as a hospital does not violate its bylaws, it has wide latitude in granting privileges," says Saul Morse, legal counsel for the Illinois State Medical Society. He adds that the courts have upheld the ability of hospitals to enter into exclusive arrangements with individuals and groups for radiology, pathology and anesthesiology services. ▲

PUBLIC HEALTH REPORT

Hepatitis on the rise

Twenty cases of viral non-A non-B hepatitis have been reported in tiny Wabash County in southern Illinois, and according to the IDPH, all of the cases are associated with intravenous drug use. No cluster of this magnitude has been seen before in this state and the federal Centers for Disease Control (CDC) also says it is the largest number of non-A non-B hepatitis associated with IV drug use reported nationwide. The CDC is using this cluster to test a soon-to-be licensed serological test that will elucidate the etiological agents of non-A non-B hepatitis.

IDPH also reports that Type A hepatitis, formerly called infectious hepatitis, is on the rise. In the first five months of this year there has been a 26% increase of cases, centered in metropolitan Chicago and in many Hispanic neighborhoods.

In the first five months of 1988, there were 268 reported cases compared to 337 cases through May of this year (a provisional number which will go higher when final reports are in, IDPH says). ▲

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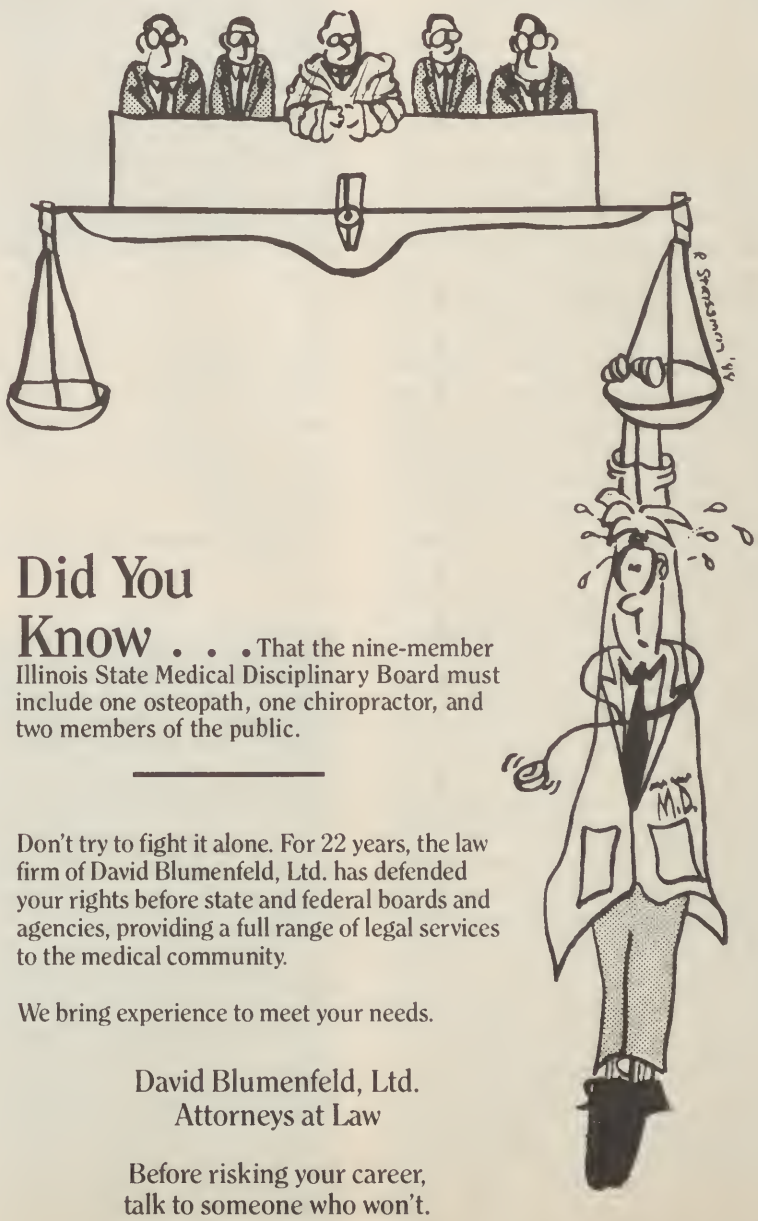
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Sales tax

(continued from page 1)

Since becoming aware of the problem, ISMS lobbyists have been meeting with department representatives and legislators to determine what additional relief might be possible. Because of the complex nature of this tax, ISMS is urging physicians to immediately consult their tax advisers to determine whether they will be obligated to collect the tax in the future, whether they have any potential past liability and what they must do to take advantage of the appeals process.

Future obligation

In its "Dear Taxpayer" letter, the department announced that, effective January 1, 1990, it will collect the service occupation tax based on the *selling* price of the merchandise sold or transferred, instead of the *cost* of the merchandise. Consequently, the onus for collecting the tax will now be on the practitioner.

Previously, the tax, which does not affect professional fees, was based on the *cost* of the merchandise to the practitioner, so most practitioners simply paid the tax to their suppliers when purchasing the merchandise and the supplier then remitted it to the department. However, according to tax attorney Garland H. Allen, the Sales Tax Review Commission last year recommended changes in the sales tax law that were later adopted by the General Assembly. Consequently, the department had no choice but to alter its collection process.

But Allen said that placing the onus for collecting the tax on the practitioner instead of the supplier will complicate the collection process. "Nobody in either the Sales Tax Review Commission, the legislature, or the Department of Revenue adequately focused on the practical difficulty that would necessarily accompany this change," said Allen. "The Department of Revenue has just now gotten itself together and faced up to the administrative nightmare that this is going to cause for them."

While the physicians most likely affected by the changes are ophthalmologists, orthopedic surgeons and pediatricians, physicians whose merchandise sold or transferred is ever 10 percent or more of their patients' total bill should register with the department before January 1. In addition, even if the cost price of the merchandise is always less than 10 percent of their total bill, physicians should still register if their supplier is not charging them Illinois state tax.

In addition to checking with their tax advisers, physicians having questions regarding their obligation should telephone the Department of Revenue at 1-800-732-8866 or write to the Illinois Department of Revenue, Taxpayer Assistance, P.O. Box 19001, Springfield, IL 62794-9001.

Potential past liability

Allen said that, in addition to potential future obligation, physicians who have never filed occupation sales tax returns, or filed returns to pay state taxes but not the local tax allowed under home rule levy authority, may be liable for tax payments as far back as 1981 when the statute of limitations for non-filers was defined.

According to the department, when the tax was first established in 1961, the state tax rate was 3-½ percent. In 1980, the rate was reduced to 3 percent for the sale of food, prescription and nonprescription medicine, drugs, and medical appliances such as artificial limbs, crutches, wheelchairs, stretchers, hearing aids, corrective eyeglasses, sterile bandaids and the like.

The state tax rate on the above items was again reduced to 2 percent in 1981. In 1984, the above items were totally exempted from the state rate, but local sales taxes ranging from 1 percent to 2-¼ percent were still in effect.

Physicians who have consistently paid the tax to Illinois suppliers may not owe any further tax. However, physicians who purchased merchandise from out-of-state suppliers who were not registered with the department for sales tax purposes, or those who thought that the 1984 state exemption also applied on the local level, are those most likely to be liable for the back taxes. Allen said the statute provides that practitioners who did not pay the tax to suppliers were still obligated to voluntarily report the purchases and pay the tax.

In his letter to ISMS, revenue department director Sweet said that he does not have the authority to abate the back taxes, nor would he recommend abatement because many other taxpayers have paid. "However, the circumstances in this situation are unique," Sweet wrote. "Therefore, the Department of Revenue will be providing appropriate relief of possible penalties and interest on service occupation tax liabilities incurred by members of the medical profession."

To be eligible for the waiver, physicians must register with the department (if not already registered) byAugust 15, pay all taxes owed, and file an appeal with the Board of Appeals. Sweet said that Board will strongly recommend that those meeting these conditions be excused from any interest and penalties, and that he will follow that guideline. ▲

Foreign grads

(continued from page 1)

the past. We need the law to keep making progress."

The sponsors are Rep. Al Ronan (D-Chicago) and Sen. Emil Jones (D-Chicago) "ISMS petitioned us to assure the fair treatment of *all* physicians applying for medical practice privileges in Illinois," said Jones. "This bill puts the force of law behind what we know in principle and practice to be right."

The Illinois medical licensing board currently reviews the medical training and credentials of all medical graduates—U.S. and foreign—seeking practice privileges here. Depending on the board's findings, graduates are individually approved for or denied temporary or full medical licensure.

The legislation reaffirms the licensing board's authority to perform this evaluation before recommending licensure. "The quality of medical training is an appropriate concern in the recruiting, licensing, credentialing and participation of residency programs of physicians," the measure says.

"But the legislation makes a clear division between such substantive evaluation and discriminatory judgments based on geographic or nationality stereotype," noted House sponsor Ronan, who added he's been approached by many physicians to address this concern.

Medical licensing board member Arvind Goyal, M.D. said H.B. 1425 will not alter his opposition to "discrimination in any form whatsoever." Himself a foreign medical grad, Dr. Goyal acknowledged the licensing board does "turn some down, and we do get sued once in a while." But he stressed everyone is turned down for a substantive reason, not because of discrimination. "People have been turned down if they do not meet legislative, legal and regulatory requirements [for licensure]," Dr. Goyal said. He added that, "All of us on the board try very hard to accommodate variations in individual medical training within limits proscribed by Illinois' Medical Practice Act." ▲

Certificate of merit

(continued from page 1)

Conflicting rulings cause confusion

This is the fourth time Illinois appellate courts have considered the certificate's constitutionality. The statute has been previously upheld in Illinois' second, third and fourth districts.

"There is now squarely a conflict between the appellate districts which needs to be resolved by the Illinois Supreme Court," said ISMS General Counsel Saul Morse. He noted the Supreme Court has so far avoided dealing directly with the constitutional issue raised by the certificate. In an earlier ruling, *McCastle* v. *Sheinkop,* "The court not only had an opportunity to rule the statute unconstitutional," Morse said, but decided the matter on narrower grounds, sent it back to the trial court and refused to consider a petition for reconsideration.

Morse cautioned against "presuming that the declination to deal with the [certificate's] constitutionality is an indication of support." The membership of the state Supreme Court has changed since *McCastle*.

Trial attorneys respond

Prominent Chicago plaintiff attorney Tom Demetrio of Corboy & Demetrio favored passage of the certificate law in 1985. "It's just good practice, because medical malpractice is very expensive litigation. If you know going in you need expert testimony, it saves a lot of time, money and emotional toll to see at the onset there's a viable claim to send to the jury," he said.

But Demetrio distinguished between sound legal practice and the law's actual constitutionality. "That's not to say that constitutionally if one does not have an expert he or she should be barred [from filing suit]," he added.

Demetrio urged attorneys representing injured people to "continue to screen their cases and avail themselves of expert testimony prior to the time the suit is filed even though it may not be required."

The Illinois Trial Lawyers Association (ITLA), opponents of the 1985 reforms, has not indicated what role it will take in any state Supreme Court Appeal. "I don't know what the association will do," said Jim Dudley, ITLA executive director.

He noted that the certificate of merit provision "was originally a proposal of the trial lawyers association, adopted and refined by the medical society's people. We [as the] loyal opposition have no problem with the act," Dudley continued. "We've always thought it was helpful." But Dudley also termed the appellate court decision well thought out.

"The 1985 legislation has made handling of medical malpractice cases so expensive that loads of people who have legitimate malpractice claims can't find lawyers to handle them because of the costs," he said, noting that lawyers can't afford to take malpractice cases unless there's an opportunity for recovery significant enough to cover expenses and fees. ▲

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Senate committee defeats amendments to UI/Reese/County merger bills

by Kevin O'Brien

A SENATE committee boosted prospects for the University of Illinois/ Michael Reese/Cook County Hospital affiliation agreements by defeating 6-4 an amendment that would have tied the 11 conditions for successful implementation contained in the Illinois Department of Public Health's (IDPH) report on health care delivery—the so-called Turnock Report—to the implementing legislation. The Committee then approved a minor amendment changing the effective date of the legislation to January 1, 1990 and sent the bills to the floor.

However, *Illinois Medicine* has learned that the University of Illinois Hospital (UIH) encountered a setback to its plans to close its pediatric and pediatric intensive care units on July 1 when the Health Facility Planning Board (HFPB) said it would require a Certificate of Need (CON) to do so.

UIH had sought to temporarily suspend the two services on the grounds that the affiliation agreements provide for Cook County Hospital (CCH) to assume responsibility for those services in December. Indeed, the university trustees subsequently approved a $442,000 contract to hire independent physicians to cover these services because of staff shortages during the transition.

Amendment defeated

On June 7, the Senate Committee on Public Health, Welfare and Corrections heard almost three hours of testimony on legislation authorizing the lease of the university hospital to CCH, forgiving the construction debt on the eight-year-old hospital, and guaranteeing that UIH non-faculty employees will retain their seniority and benefits when they become county employees.

Committee Chair Sen. Margaret Smith (D-Chicago) offered an amendment that would have significantly impeded the university's plan to begin implementing the Reese part of the package. The amendment would have required the university to affirm its compliance with the 11 conditions in the Turnock Report at least 30 days before implementing any part of the agreements. The amendment also called for IDPH Director Bernard Turnock, M.D., to concur that the conditions had been met.

The Turnock Report, submitted in early April at the request of university president Stanley O. Ikenberry, concluded that the proposed affiliations could go forward provided that the 11 conditions were met. University trustees pledged adherence to the conditions when they approved the agreements on April 13. The first condition specifically provides that implementation of the Reese agreement not "go forward ahead of the University/Cook County Hospital affiliation."

However, critics testifying at the Senate hearing contended that the amendment is needed because the university is already implementing the Reese agreement by announcing the closure of the UIH general pediatrics and pediatrics intensive care units despite unfinished negotiations with the county.

"I must tell you, you have to codify these things, or we're going to convert a health care crisis in the inner city to a health care disaster in the inner city," said Truman Anderson, M.D., UIH medical staff member and former dean of the College of Medicine.

Ikenberry denied the university is violating the 11 conditions, saying that the trustees fully subscribe to them. "Some of the conditions, I might add, are the responsiblity of the Governor's office and the General Assembly, and other parties," Ikenberry said.

UIH seeks Certificate of Need waiver

However, in a May 23 newsletter distributed to hospital staff, UIH director Donovan Riley stated that "On or about July 1, 1989, the University of Illinois Hospital will close its inpatient General Pediatrics Unit and the Pediatric Intensive Care Unit." Riley said the changes were necessary because of a decreasing patient base in these units. Pediatric patients would then be transferred to either Reese or CCH and pediatric residents would begin their training at Reese.

Moreover, in a draft letter to HFPB executive secretary Ray Passeri obtained by *Illinois Medicine,* Riley seeks approval "to temporarily suspend Pediatric and Pediatric Intensive Care services at UIH," presumably without obtaining a Certificate of Need (CON). State law requires that a CON be obtained whenever a hospital or service within a hospital opens or closes.

According to an UIH internal memo also obtained by *Illinois Medicine,* a university official reports that Passeri responded to the UIH request by saying that the hospital would need a CON, and that the earliest the HFPB could consider such an application is August. The memo quotes Passeri as saying that the "eyes of the world are on the activities of the University and that all i's should be dotted and t's crossed."

In a telephone interview, Passeri confirmed that UIH had approached him for a waiver of the CON. He said that he told UIH officials that the HFPB regarded the suspension of the two services as a closure because County Hospital, not UIH, would be reestablishing the services. Consequently, the CON would be required. He also said that the CON application process would prevent the HFPB from considering an application until August at the earliest.

County continues negotiations

Meanwhile, negotiations between the university and CCH continue, according to Senate committee testimony of CCH director Terrence M. Hansen. "It had been our hope that those negotiations would be completed last week so the Cook County Board could have gone into executive session on Monday to consider informational presentations by myself and other members of the hospital staff," Hansen said.

Responding to criticism from senators that the commissioners have yet to see any of the agreements, Hansen said that "(Cook County) President (George) Dunne explained to the Board of Commissioners that he felt it was an executive negotiation process, and that it should not be witnessed or participated in by the legislative branch of county government."

Hansen said that he had "significant problems" with the conclusions of a recently released report that said the county portion of the affiliation could cost taxpayers more than $147 million per year. Hansen testified that the cost of implementing the agreements should be no more than $125 million, which would include $19 million to renovate UIH as a children's and maternity center. Moreover, Hansen could not accurately project the CCH deficit for the next fiscal year until current ICARE negotiations with the Illinois Department of Public Aid are completed. ▲

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Emergency medicine—Dubuque—opening available for qualified individual to join incorporated group of three BE/BC emergency physicians. Unique and enjoyable practice, excellent compensation, complete career opportunities, and highly livable community. Write: NET, PC, c/o Mercy Health Center, Emergency Department, Dubuque, IA 52001, or call Mark Singsank, M.D. (319) 589-9666.

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Antigo, Wisconsin: Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

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Certified family-practitioner seeking part-time positions. Reply to Box 2048, c/o *Illinois Medicine,* Twenty North Michigan Avenue, Suite 700, Chicago, IL, 60602.

Board-certified Ob/Gyn seeking part-time positions. Please reply to Box 2047, c/o *Illinois Medicine,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

For Sale, Lease or Rent

Family practice—Busy northwest suburban practice close to many hospitals, for sale. Suitable for BC/BE family practitioner or general surgeon willing to do some general practice. High income. Available immediately. Reply to Box 2133, c/o *Illinois Medicine,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

Practices for sale: PSL, as exclusive medical brokers, is the largest California based company specializing in practice sales. Our specialized services include appraisals, financing, and physician recruitment. Request our free monthly practice list or contact us for a confidential interview. PSL, Inc., 4122 E. Chapman, #10, Orange, CA 92669. (714) 771-4431.

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How resident physicians cope . . . 10

Illinois Medicine

July 7, 1989 ILLINOIS STATE MEDICAL SOCIETY

County Dems OK U.I. lease

by Kevin O'Brien

THERE WAS LITTLE doubt of the outcome when the Cook County Board of Commissioners met in special session June 27 to vote on leasing the 500-bed University of Illinois Hospital (UIH) and make the university Cook County Hospital's (CCH) primary academic affiliate.

"It's a Dunne deal," said Midwest Community Council executive director Joseph Banks.

In fact, although Cook County Board President George Dunne said he was praying he had the votes, he really knew he did. "The question as to who was going to vote yes or no had for a long time been obvious," he conceded.

But it was a rancorous session marked by partisan posturing, with the board voting 9-7 along straight party lines for a resolution approving the agreements. In a less strident action, the commissioners overwhelmingly amended the resolution to include the 11 conditions of the so-called Turnock Report. These are the conditions that Illinois Depart-

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Wm. Daniels/The Photo Partners

Cook County Board Republicans Carl Hansen (top-left) and Joseph Mathewson (bottom-left) engaged in sometimes heated debate on the University of Illinois affiliation with Democrats George Dunne (top-right) and John Stroger (bottom-right).

Chicago Med School won't appeal court's ruling

by Kevin O'Brien

ILLINOIS MEDICINE has learned that the University of Health Sciences/The Chicago Medical School (CMS), and a separate entity, Chicago Medical School Inc., of Virginia, will not appeal a Cook County circuit court decision throwing out the school's permit to build a 224-bed tertiary care hospital in North Chicago. The deadline for filing an appeal in the case was June 30.

In a telephone interview on June 27, CMS dean and executive vice president Marshall A. Falk, M.D. said that construction of a new hospital is no longer viable due to changing financial conditions during the almost five-year period that CMS has sought to start the project. He also said that the uncertainty of how long further litigation would take was a factor in the school's decision.

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Court ruling could boost hospital unionizing efforts

by Janice Rosenberg

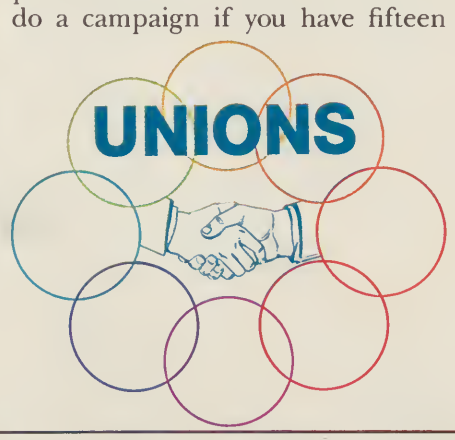
WITH GENERAL membership having decreased across the country, unions are looking to the health care industry as the next major field for their organizing efforts. The outcome of a case now pending in federal district court is certain to have an important impact on these efforts.

Unions organize groups of workers into bargaining units. In the health care field for more than fifty years the National Labor Relations Board (NLRB) has considered approval of these bargaining units on a case-by-case basis. On April 21, 1989, the board changed this by announcing rules that authorize the establishment of eight bargaining units in any hospital. On the same day the American Hospital Association filed suit challenging the NLRB's rule making authority. On July 20, Judge James B. Zagel will announce his decision on this suit.

NLRB rules will have immediate impact

According to Brian W. Bulger, a partner at Katten Muchin & Zavis, the firm representing the AHA in its suit, "Enforcement of the suggested NLRB rules will have an immediate and irreparable impact on the statutory rights of employees to refrain from engaging in union activity, on employee morale, and on the stability and economic health of hospitals. This will, in turn, threaten the delivery of quality patient care. All other issues aside, that is one of the AHA's main concerns."

Currently most hospitals deal with three or fewer units. These units tend to be broadly based, representing, for example, all professional or all technical workers. "The NLRB has been lobbied by union organizers to try to break down the organizing units into very small units," said Daniel Mulvanny, an attorney at the same firm and former vice president and legal counsel at the Illinois Hospital Association. "It's much easier to do a campaign if you have fifteen



employees to organize and they're all operating engineers than it is if you're trying to organize all the non-professional employees."

Illinois unions lack downstate support

In Illinois, Mulvanny notes, hospital unionization campaigns have for the most part involved non-professional support staff at Chicago metropolitan area hospitals. Mike Gavin, business agent for the Union of Operating Engineers Local 399, says that the union represents skilled maintenance and repair employees in more than one half of all Chicago area hospitals, but none downstate. "The trend not to unionize is part of the small town atmosphere," he said. "Employees fear losing their jobs in one and two industry towns."

The Hospital Employees Labor Program of Metropolitan Chicago (HELP) is also active, representing workers in service, maintenance, di-

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Illinois cost containment report tallies charges for illness

THE ILLINOIS Health Care Cost Containment Council (IHCCCC) recently published its third annual consumer guide to charges at Illinois hospitals by illness categories. IHCCCC's report lists the top 10 illnesses that hospitalize patients over age 64 and under the age of 65. The brochure also details the hospital's average charge per illness, average length of stay and number of discharges. All data reflect 1987 calendar year experience.

IHCCCC's promotion of health care cost containment through competition and consumerism is a result of the Illinois Health Finance Reform Act of 1984 passed by the General Assembly.

The 11 member council, represented by health care providers, businesses, insurers and consumers was established in 1984 to "help patients and others better understand what happens within the health care delivery system so they may become more informed purchasers of health care," says John R. Noak, Ed.D., IHCCCC executive director. "The annual guide gives patients considering elective surgery a better sense of responsibility of what it might cost them. It also serves to open up dialogue with their insurers," he adds. The guide makes no comments on the quality of care rendered.

"The report can help consumers find lower health care costs if they use the data intelligently as a starting guide," says Robert Burger, Illinois State Medical Society's (ISMS) vice president of health care finance and member of IHCCCC's board of directors. "While the council has worked to balance the needs and desires of various interest groups reflected on the IHCCCC board, both hospitals and physicians need to ensure people are provided with an accurate picture of the health care system along with an explanation of certain issues they should be aware of when using the report's statistics."

Physicians add perspective to data

Donald Rokosch, M.D., chairman of the ISMS Council on Economics which reviews IHCCCC activities, says, "Physicians need to become aware of the fact that data exist today about charges, costs, and practice patterns that were not available even as recently as 1985. These data will be increasingly used to evaluate both financial and patient care aspects of the health care system. More than ever, physicians today need organized medicine's involvement in data issues to make sure that the information presented is not misleading. Statistics can be put in many different perspectives. For example, it's possible to drown in a river with an average depth of three inches."

"Cost is a factor when selecting a hospital, but there are many other considerations in choosing both a hospital and physician, such as one's perception of quality of care, personal comfort and satisfaction to name a few," says Burger. He notes that to some extent, a patient's choice of hospital is going to be influenced by the choice of physician. "In many instances, patients choose a hospital because it's where their physician practices," he says, "and if a patient wants to go to a different hospital, it may be according to where else his or her physician has practice privileges."

Understanding hospital charge data

Consumers should understand that the hospital charge data do not equal the hospital's reimbursement per charge. "A Blue Cross patient and an Aetna patient entering the same institution, for example, may generate bills that have the same charge, but different payments to the hospitals from the insurance companies based on the extent of each company's market power and its ability to negotiate discounts. Insurance companies with greater market concentrations will have greater discounts than the average carrier," says Burger.

Cost is a factor when selecting a hospital, but there are many other considerations . . .

"The pressure on hospital charges varies tremendously from institution to institution depending on the amount of Medicare and Medicaid patients they get," adds Chris Bailey, director of planning for the Illinois Hospital Association (IHA). He says, "The more Medicaid and Medicare patients hospitals have, the greater the pressure to compensate for their losses by increasing charges to those not on Medicaid and Medicare. Many patients have insurance like Medicare that pays a flat rate per day for its clients."

According to Bailey, patients should note that the charge data are also unadjusted for the variation of the severity of illnesses among hospitals. "The information provided is accurate as far as it goes. The difference comes in with what the study doesn't tell you. It's not truly comparing apples to apples. One diagnosis related group (DRG) at one hospital is not necessarily the same as that same DRG provided at a different hospital."

"The DRG or illness categories among hospitals are not a uniform set of services. There are many variables that would cause a charge for a particular patient to vary within a DRG. On average for example, Rush-Presbyterian-St. Luke's Medical Center has much more severe cases than certain DRGs at a community hospital. You would expect Rush's charges would be greater because of the higher severity of the patients they treat," says Bailey.

Increasing expenses

Hospitals in the state of Illinois rang up $12 billion for patients' health care last year, not including charges for patients at hospital subsidiaries, according to the IHCCCC. Hospital expenses more than doubled in the last decade according to the American Hospital Association.

"The problem of rising hospital costs has been a long established civil war in the state. It's useless to think about where we are going to put the blame. We need to address the issue of cost containment as hospital costs increase and access to health care becomes more of a problem," says Noak.

Administrators evaluate system

Charles B. Van Vorst, president and chief executive officer of Carle Foundation Hospital in Urbana and a member of the IHCCCC board of directors says, "Hospitals and physicians really have to work together and use their resources appropriately today if we don't want the ultimate result to be higher costs to patients and government constraints on the industry. Physicians and hospitals need to look at how we can interrelate our services to reduce the length of stay, reduce taxes and add tests or procedures that will be more cost effective."

"We're looking at how we can rearrange our resources to take care of an increasingly sicker population. But with less reimbursement, we also must look at ways to keep our quality up," says Van Vorst. He adds, "We're doing better pre-admission screening, making sure that the demand patients present for health care is real. We're also changing our systems to do discharge planning at the time of admission."

Noak says the brochures are being used widely in certain instances throughout the state. "Some people in an HMO or PPO may not have complete control over which hospital they go to, but we do find organizations that make these decisions use the charges that are contained in this document as a starting point. It's a valuable tool for insurance companies such as Blue Cross/Blue Shield, HMOs or PPOs."

IHCCCC will distribute 40,000 brochures this year at state fairs, libraries, schools, consumer programs and directly to the public. Free copies may be obtained by calling 1-800-325-9564. ▲

Look to the next *Illinois Medicine* for a full recap of Illinois General Assembly action!

Physician Facts

1987 Charges at Illinois Hospitals by Illness Categories

Under Age 65

	DRG*		No. of Discharges	Avg. Length of Stay	Avg. Charge Per Discharge
1.	373	Normal Childbirth, Mother Only	71,441	2.5 days	$ 1,807
2.	373C	Normal Childbirth, Mother & Baby	37,912	2.8 days	$ 2,476
3.	390/391	Normal Childbirth, Baby Only	97,564	2.9 days	$ 759
4a.	371	Cesarean Section, Mother Only	20,620	5.0 days	$ 3,942
4b.	371C	Cesarean Section, Mother & Baby	11,632	5.1 days	$ 5,351
5.	430	Psychological Problems	25,267	17.0 days	$ 7,236
6.	243	Medical Back Problems	20,844	5.5 days	$ 3,122
7.	359	Uterine Related Problems	19,618	5.4 days	$ 4,532
8.	098	Bronchitis & Asthma, Ages 0-17	16,793	3.4 days	$ 2,341
9.	188	Digestive Tract Problems Ages 18-64	16,493	3.5 days	$ 2,327
10.	435	Substance Abuse	14,184	11.4 days	$ 4,630

Age 65 and Older

	DRG*		No. of Discharges	Avg. Length of Stay	Avg. Charge Per Discharge
1.	127	Heart Failure and/or Shock	23,498	8.3 days	$ 6,227
2.	140	Angina	14,566	5.3 days	$ 3,896
3.	14	Stroke	14,250	10.6 days	$ 7,553
4.	89	Simple Pneumonia and/or Pleurisy	14,076	9.3 days	$ 7,130
5.	182	Digestive Tract with Complications	11,626	6.3 days	$ 3,994
6.	296	Nutritional and Metabolic Disorders	9,180	8.0 days	$ 5,307
7.	138	Cardiac Arrhythmia	8,862	6.1 days	$ 4,739
8.	96	Bronchitis and Asthma	8,482	7.4 days	$ 5,267
9.	15	Transient Ischemic Attack	7,881	5.7 days	$ 3,755
10.	209	Major Joint & Limb Replacement	7,176	14.1 days	$13,205

* DRG is a diagnosis related group or illness category.

Source of Data: Illinois Health Care Cost Containment Council

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On the Legislative Scene



by Caryl Carstens

MD office labs . . . The General Assembly has approved legislation to delay the deadline for applications under the new state Clinical Laboratory Act from October 1 to December 31.

The legislation also ensures that physicians who operate laboratories will not be caught between state law and potentially conflicting federal regulations which will be phased in over the next two years and supercede the state standards.

The state law, which became official July 1, affects physicians who maintain their own office laboratories and requires them to be registered, or to obtain a permit or a license in order to continue to perform lab tests in their offices.

Physicians who themselves perform tests for their patients would be required to register with the Illinois Department of Public Health (IDPH), but are exempt from fees and other regulations. Physicians' laboratories testing patients outside the practice would be considered fully licensed facilities and would be routinely inspected and required to meet other more stringent standards. IDPH will determine which tests are considered simple enough to qualify for the lowest level of regulation. The IDPH rules are scheduled for publication in the July 15 *Illinois Register.*

Physicians with office laboratories should contact IDPH for an application packet, including a copy of the Clinical Laboratory Act, its rules and an application form.

FMG discrimination . . . Legislation barring discrimination against foreign medical graduates applying for Illinois licensure has sailed through the General Assembly and awaits action by the governor. ISMS has pressed hard for passage of the legislation to prohibit discrimination against any physician "because of national origin or geographic location of medical education."

Rural health . . . Most of the rural health legislation, sponsored by Sens. James Rea (D-Christopher) and Vince DeMuzio (D-Carlinville), Reps. David Phelps (D-Eldorado), Tom Homer (D-Canton) and Tom Ryder (R-Jerseyville), has passed both chambers, but the bill to provide most of the necessary funding was endangered as *Illinois Medicine* went to press.

Legislation which would earmark an out-of-state insurance company tax to pay for the program has cleared the Senate, but was defeated in the House. Because funding provisions were attached by amendment to another bill still due for House consideration, supporters will get a second chance to pass it. If the House refuses, the funding legislation will go to a conference committee, where House and Senate members will try to bridge their differences.

Some funds are also provided for by a bill allowing taxpayers to contribute part of their income tax refund to the program. That measure was expected to go to the governor after passage by both Houses as the session drew toward its close.

Clean Indoor Air Act . . . Legislation to control smoking in public areas has passed the Senate and been returned to the House for approval of Senate amendments.

Senate amendments to the bill have been criticized for being too lenient. The Senate relaxed smoking prohibitions in the bill, so they do not apply to factories, warehouses and other work areas not open to the public. Another Senate amendment guarantees that smoking areas are to be established in certain circumstances.

AIDS . . . ISMS-backed legislation abolishing the requirement for pemarital AIDS and syphilis tests has passed both houses and been sent to the governor for approval. A package of AIDS bills is set for two separate conference committee reports as *Illinois Medicine* goes to press.

Death definition . . . Senate-approved legislation to establish a statutory definition of death was defeated in the House. It is expected to reappear next year, following the recommendations of Cook County State's Attorney Cecil Partee's Task Force on the Removal of Life Sustaining Treatment, in which ISMS is participating.

Immunity from liability . . . A Senate-passed bill to protect physicians from liability when they have provided medical services without compensation as part of a community organized "free clinic" was tabled in the House and is dead for this session. ISMS strongly supported the legislation, which expanded immunity provisions of the Good Samaritan Act.

Drug dependent mothers and infants . . . Legislation to establish a

(continued on page 13)

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REPORT FOR *Illinois Physicians*

PAYEE GUIDELINES

The following are payee guidelines for Blue Shield reimbursement.

Physicians will receive payment directly from Blue Cross and Blue Shield of Illinois (BCBSI) under the following circumstances:

- The physician submits the bill on a HCFA-1500 form and includes his/her Blue Shield ten (10) digit provider number in item #31 and indicates that the bill is unpaid by entering an "X" in the "yes" box in item #26.

- The subscriber submits the bill to BCBSI and requests that payment be assigned to the physician. BCBSI is revising its Major Medical claim forms to include a provision specifying assignment of benefits; in the interim, we will continue to acknowledge the subscriber's written request that payment be made directly to the provider. If unstated, payment will be made to the subscriber.

Subscribers will receive claim payment from BCBSI when they submit their bills directly to BCBSI and do not request assignment of benefits to the physician. Therefore, it is important for MPP/PPO contracting physicians to instruct subscribers who request a copy of their bill not to submit it to BCBSI directly, in order to ensure BCBSI payment to the provider.

(This report is a service to the physicians of Illinois)
7/7/89

Editorials

Evaluating health care charges: more than a "numbers game"

The Illinois Health Care Cost Containment Council's recent report on hospital charges typifies an impressive "information explosion" which places ever-growing amounts of computer-generated data and statistics on health care charges at any seeker's fingertips. Increased information access, however, carries an important caveat: meaningful evaluation requires accurate interpretation before potentially harmful conclusions are drawn.

Statistics on hospital charges, costs, length of stay, care characteristics, mortality data and other factors make undeniably interesting reading. But, viewed without knowledgeable perspective or explanation, the figures can create an erroneous, alarming and misleading "numbers game" which both the public and professionals stand to lose. Many physicians are concerned that the data being generated will be used to make statements about quality of care. This activity is far more subtle than providing statistical indicators alone. And the patient's perception of care provided is heavily influenced by the relationship with his or her physician—a critical element which doesn't register in statistical reports. ISMS has always actively sought to assure—and continues to advocate—that acquired data are used fairly and responsibly by those who choose to score and rank the health care delivery system. We will continue these important efforts.

Praising unsung heroes

In simpler societies and days gone by, whenever a neighbor needed assistance, everyone from miles around pitched in to help solve the problem or lend a hand. Today, it's a different story. Contributing time or effort to any cause has become, sadly, a rapidly declining tradition. As a result, too many organizations must reduce necessary activities due to inability to recruit volunteers from their membership.

That's why we all owe a tremendous debt of gratitude to the many ISMS members who willingly serve on the councils and committees so vital to our survival. These busy physicians make their colleagues' concerns—and those of organized medicine—a top priority. Working without any compensation, they contribute countless hours, wise counsel and effective leadership to help achieve the best possible medical environment for physicians and their patients, as well as the most worthwhile direction for the future of American health care.

Thanks for caring. We wouldn't be here without you. ▲

Illinois Medicine

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"I've come to realize that 'death with dignity' is not *having to wear one of these silly gowns when you go."*

Guest Editorial

Use courts to deter cocaine babies

by Paul Logli



Recently this office sought to bring charges against a 24-year-old mother as a result of the death of her two day-old child. According to medical authorities, that death was directly related to the mother's use of cocaine during her pregnancy.

That prosecution never advanced beyond the Winnebago County grand jury which decided not to indict the mother who had been previously charged on a police complaint. Thus this case concluded without a chance to argue important issues before a judge or jury.

It is apparent that the problem of children born either exposed or addicted to alcohol or other drugs has become a difficult issue in practically every city and state.

I received a disturbing and heartbreaking letter from an adoptive mother in the Chicago suburbs. Her child, now four years old, suffers from a multitude of physical problems ranging from cerebral palsy to bony deformities caused by the biological mother's alcohol and drug abuse during pregnancy.

The biological mother was aware of the damage she was doing to her child while still in the womb and in spite of treatment at one of Chicago's prenatal centers for drug abusing pregnant women, the child was still damaged by the use of cocaine and other drugs throughout all stages of the pregnancy.

The letter writer states, "my heart breaks for my little girl, who though physically disabled, is intellectually intact as she watches her siblings run and play. She, even at this young age, wonders why she cannot! The truth is, she is a victim of a society that makes laws of convenience."

I have called upon the legislature of the State of Illinois to set about the difficult task of first establishing the protection of the health of our newborns as a priority in our medical, social and legal structures. Secondly, having established this priority, they must work with experts in these areas to set out the boundaries of unacceptable behavior by pregnant women which may constitute a substantial threat to children who survive birth, but who are then captive to serious medical and educational disabilities.

Lastly, the state must set out a definition of behavior which is so wanton in its disregard for human life and safety that persons engaging in it must be held responsible in the criminal courts. I firmly believe criminalization of certain egregious behavior is an absolute requirement to go along with all of the social and medical planning, which is also certainly needed.

I acknowledge that education, intervention, and the greater availability of drug treatment facilities for rich and poor alike are important in establishing a long-term solution to this problem. However, I know from my experience as a prosecutor and in day-to-day life that people will not always do the right thing for the right reasons. Everyday we see persons who know the difference between right and wrong, but who are unwilling to conform their behavior to acceptable standards. Obviously there is no exception in the case of pregnant women.

I have decided to continue to play a key role in assisting our legislative leaders to draft appropriate legislation which, through criminal sanctions, discourages individuals from engaging in behavior harmful to the most innocent and defenseless members of our society—newborns. I also encourage others, including the medical community, to assist the state in formulating and funding programs which will encourage and provide appropriate pre-natal care and drug addiction treatment to anyone, regardless of economic ability.

Only a comprehensive, well-funded effort which acknowledges the roles of intervention, prevention, education and deterrence can possibly accomplish the objective of guaranteeing the right of our children to a healthy birth. ▲

Paul Logli is an Illinois State's Attorney in Rockford.

Board Briefs

The Illinois State Medical Society's Board of Trustees convened June 10, 1989 in Chicago to ratify council and committee appointments and debate a broad range of medical issues involving Illinois MDs. The highlights are:

Chairman and executive committee reports

The Illinois Supreme Court in April upheld the constitutionality of the state's Medical Practice Act against a challenge by naprapaths seeking licensure. The plaintiffs have filed a petition for reconsideration, but there is no word yet on the high court's decision to accept or reject it. See the May 26 *Illinois Medicine* for details on the naprapathy decision.

New ISMS councils and committees are fully up and running for the 1989-90 policy-making year. The board approved over 250 ISMS physician, resident, student and auxiliary members to serve on some 30 committee and council rosters. ISMS Chairman Harold L. Jensen, M.D. publicly recognized these members' time and efforts in debating and building ISMS policy recommendations on the host of tough issues confronting medicine today.

The ISMS annual House of Delegates meeting will continue to run for three days during the spring. The Executive Committee and board had considered shortening the official policy making session, but decided not to curtail the meeting's motivational and educational programs.

ISMS will offer seven travel programs to members and their families during 1990, through Maupintour Travel Service and Trans-Global Tours. The tour packages include trips to the Carribean, Hawaii, London, New England (fall foliage tour), Austria and Disneyworld.

The ISMS 1989 all-member conference will take place in Oak Brook during November. Specific dates will be announced shortly.

The Illinois State Medical Society's new Springfield office, funded through an investment of the Illinois State Medical Inter-Insurance Exchange, will be completed later this year. The building will house ISMS governmental affairs and regional ISMIE claims staff, along with additional rental space. The board decided that ISMS should lease its current building, due to its prime location and potential for appreciation.

Medicare and public aid

Medicare issues have topped the agenda of the Third Party Payment Processes Committee, which reported on the federal government's preadmission certification, ICD 9-CM coding and unique physician identification number (UPIN) initiatives. More details on each can be found on page 13 and in previous editions of *Illinois Medicine*.

An emergency Medicare resolution for presentation by the Illinois delegation to the American Medical Association (AMA) was approved by the board. It urges Illinois' Medi-

(continued on page 14)

Illinois Snapshot

Should physicians be obligated to tell their patients to quit smoking?*



Anita Demik

42 years old, secretary, former smoker

Society is becoming more health conscious and the hazards of smoking are more prominent today than they've ever been. It's a doctor's strong medical obligation to tell his patient to stop smoking just as it is if his patient is overweight or is suffering a heart attack. I was a smoker and I got sick of the cigarette smell, dirty ash trays and morning cough.



Hy Spreckman

71 years old, wholesale jeweler, former smoker

More physicians need to tell their patients to quit smoking. My doctor told me to stop ten years ago when I had bad chest pains. His advice was a big help to me because I felt like a new person. Smoking is like poison. You need to realize that people like John Wayne and Yul Brynner admitted smoking is what was killing them.



William D. North

59 years old, attorney, former smoker

I go for annual checkups and I smoked for many years. When my doctor told me to quit, I did the next day. If doctors believe that smoking is bad for you, and I think the evidence is pretty clear, then they should advise patients to stop. In some cases society is over-health conscious, but when it comes to smoking and alcohol, we're under-health conscious.



M.S.

27 years old, closet smoker

Unless smoking poses an immediate harm to patients, like if the person is suffering from asthma, then physicians shouldn't have the right to tell their patients to stop smoking. I am told to quit constantly by my doctors and sometimes it bothers me. It's an addiction, but I'm not a heavy smoker, my lungs are clear and I work out.

**based on recent interviews in downtown Chicago*

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

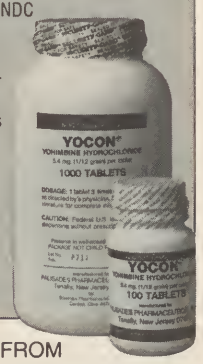
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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A corporation is a separate entity and can be named in a claim or lawsuit. If coverage for the corporation has not been obtained, no coverage will be afforded. This is also true for other types of policies you may have for your practice, so it is important that you notify all of the carriers providing coverage and request that they name your corporation as an additional insured on those policies.

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Insights

This is the first in a series of articles authored by Policyholder Services Committee (PSC) members on what physicians should know about professional liability insurance.

Purchasing professional liability insurance



Boyd E. McCracken, M.D.

by Boyd E. McCracken, M.D.

PROFESSIONAL liability insurance is a major budget item for any medical practice today. When purchasing this insurance, few physicians expend the time and attention for the cost that they would if purchasing a piece of medical equipment or an automobile. In fact, there is probably no other item on which a physician would spend so much money without first carefully evaluating needs, having all available product information and getting all questions answered.

Physicians should take the time to learn to be better consumers where professional liability insurance is concerned. This also includes understanding the insurance policy's coverages and limitations, and rights and responsibilities as an insured, *before* a claim occurs.

The professional liability insurance application is the first essential step in obtaining the appropriate insurance. The application defines the persons, practices and entities to be insured. It also provides the underwriting information to evaluate the applicant and rate the appropriate premium.

Separate applications are required for each physician in the practice, as well as one for the partnership/corporation. Coverage for employed paramedicals must be requested according to the insurer's requirements. Some companies include them by simply asking the number employed for each job classification, or you may be required to name them individually.

The insurance application should guide you in requesting the coverage you desire. You must provide all of the information accurately and completely. As is true with any insurance policy, failure to report or any misrepresentation of information will result in denial of coverage or cancellation of the policy. This also applies to any failure to report material changes in your practice after the insurance policy is in effect.

Some tips on completing insurance applications for new coverage or renewal of existing coverage:

—Allow a minimum of 4-6 weeks for the application to be considered.
—Complete all sections of the application accurately and completely. Do not leave any blanks. Omissions or misrepresentations can result in denial of coverage or cancellation of the policy.
—Correctly list the *legal name* of all persons, partnerships or corporations to be insured.
—Provide all attachments and supporting information requested. Failure to do so will delay processing your application until the information is provided.
—Review the completed application to see that it clearly defines the persons and entities to be insured and the practices and delivery systems operating. Add any other supporting information you think may be pertinent for the underwriter to review with your application. A description of risk management programs and practices is an example.
—Sign all applications as indicated. Keep a copy for your files.

When you receive your policy, check it promptly to see that the coverages you requested are listed. First review the declaration pages and endorsements to see that the requested limits, covered persons and entities are included, and that the *legal names* are listed correctly. If not, request corrections promptly. The corrections will be added by endorsements amending the policy. These and any other endorsements added to your policy should be filed with the policy promptly on receipt.

Second, review the policy language so you understand the policy's definition of a claim, your reporting requirements and other responsibilities as an insured, and covered items and exclusions. Call your underwriter if you have questions after reviewing the policy.

Physicians should give the same attention to policy renewal that is required when purchasing the original policy. Take the time to be a better consumer when purchasing insurance. If you don't, it could be a very expensive mistake. ▲

Dr. McCracken is a board certified family physician in Greenville, Illinois. He is a member of the Illinois State Medical Inter-Insurance Exchange (ISMIE) and chairman of the Policyholder Services Committee (PSC).

Athletes, MDs, prepare for Prairie State Games



by Tara McClellan

WHILE THOUSANDS of the world's best athletes gathered in Los Angeles to test their prowess at the 1984 Olympics, Illinois' amateur athletes tested their abilities at the first state version of the Olympics, the Prairie State Games.

The Prairie State Games have become increasingly popular among athletes and this year more than 12,000 Illinoisans are expected to contend in the regional and final competitions for: archery, basketball, boxing, diving, fencing, gymnastics, judo, soccer, swimming, and volleyball, among others. Some regions will offer special events such as water polo and horseshoes. Regional winners compete at the games' finals in Champaign between July 14 and 16.

Providing medical coverage for this type of large-scale athletic event is a multi-faceted challenge. The games encompass several different sports with varying injury potentials and are held at numerous venues in the middle of a hot Midwestern summer. Edward Grogg, M.D., a pathologist at Urbana's Carle Clinic and founder of his own sports medicine clinic, has coordinated the games' medical coverage since their beginning.

As the games' medical director he's responsible for securing the volunteer medical corps of physicians, athletic trainers, emergency medical technicians, and other support personnel. Dr. Grogg also establishes the games' medical policies, obtains supplies, sets up a medical command center, and generally oversees all aspects of the games' medical care. The medical corps plays a critical role in the games since the medical director has the authority to change the rules or completely halt play if circumstances, such as extreme weather conditions, necessitate.

Dr. Grogg says one of the most difficult responsibilities during the first few games was "to get the volunteers." But now many physicians return every year.

"We've established that the games are the place to be if you're interested in sports medicine," Dr. Grogg says. "We try to make it fun and educational."

Dr. Grogg says the fun comes from nightly social events and the camaraderie that develops from working with nationally-known sports medicine experts as well as athletic trainers and coaches. The medical corps members share experiences, and attend a pre-games sports medicine seminar held each year. This year's topic is "Weight Loss and Weight Gain in Athletes."

Dr. Grogg says he'd love to have more physicians help at the games. Volunteers receive free room and board at University of Illinois dormitories, complimentary shirts, hats, and bags.

"Come for one day or one event. We make it painless and easy, just come to the medical command center (at the University of Illinois' Memorial Stadium) and say 'Put me to work.' " Dr. Grogg says physicians are also welcome to bring their families and tour the center or any of the event venues. To offer assistance in advance, call Dr. Grogg at Carle Clinic: 217/337-3342.

"The medical corps has done a marvelous job," according to Jeff Sunderlin, director of the games and executive director of the Governor's Council on Health and Fitness. "We're a model for medical coverage [of state games], and others call us to see how to do it."

Most injuries at the games are orthopedic, and a fair number of heat-related problems arise. But the medical corps has had some unusual medical situations, like a 33-year-old swimmer's request for "emergency chemotherapy." The woman had altered her chemotherapy treatments to fit in with the games schedule and her pain had increased. Her condition was verified, therapy was administered, and the same day she placed in five of six events.

This year's medical corps will be embellished by students from the games' first student athletic trainer camp to be held July 9-16 at the University of Illinois. H. Bates Noble, M.D., curriculum director of the camp and chair of the Illinois State Medical Society's (ISMS) sports medicine committee, says the ISMS committee and the Illinois Athletic Trainers Association developed the idea for the camp as an opportunity for students interested in medicine to become student trainers while working with some of the best "sports medicine people in the state."

The camp is open to 25 high school and college students from anywhere in the nation. They'll receive athletic training instruction through lectures and hands-on experience with certified trainers at the games. Dr. Noble encourages physicians to recommend the camp to any medically-interested students. For more information, contact Ellie Wolf: 312/431-3300. ▲

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An exception: Fairbury Hospital

On November 1, 1985, employees at Fairbury Hospital became the exception to the "no unions downstate" rule. The 117 bed hospital is located in Fairbury, Illinois. The town, thirty miles northeast of Bloomington, has a population of just over 3500. In 1985 changes in the hospital census led to cost cutting. Conflict among physicians created an atmosphere of uncertainty. According to John Tummons, Ph.D., who became the hospital's chief executive officer in 1987, "The administration had not been communicating well with the employees, so they started looking for someone to support them."

The employees had written letters to the administration asking for explanations of what was going on. The leadership at the time, Tummons notes, was strongly autocratic and did not respond. Working with forty-two eligible employees, the Illinois Nurses Association organized an all-professional bargaining unit.

"We were ripe for the union," said Tummons. "They had the opportunity to really shine, take things in hand and prove what they could do. We negotiated a contract with them and then worked with employees trying diligently to communicate and make them feel like they were a part of the hospital. What we were able to do was upstage the union."

Another point in the hospital's favor was that the union did not have a closed shop. This meant that, as employees became increasingly satisfied with circumstances at the hospital, they could drop their membership. The INA unionization lasted until May, 1988. According to Tummons, the union decertified themselves without an employee vote because they realized that the employees were solidly behind the hospital and the administration.

Tummons agrees that smaller hospitals may have an easier time making their employees feel like part of a family. On the other hand, he points out, at a small hospital everybody knows what is going on. "You have to be honest and open," he said. Tummons is certain that the unions have petitions "ready to go" throughout the state, on hold until Judge Zagel makes his decision.

"The hospitals have a window of opportunity between now and July 20 to build some credibility," said Tummons. "After that, the union's going to come in and say 'You're doing it only because of us.' " ▲



Fairbury Hospital, a 117-bed hospital in Fairbury, Illinois. (Photo courtesy of The Fairbury Blade.)

Unions

(continued from page 1)

etary, and other unskilled areas. Norbert Ciesil, business manager for local 73, reports wide representation in the city but none downstate. "We have fewer units in the suburbs, too, due to the large number of part-time employees harder to organize."

These two unions along with the International Brotherhood of Electrical Workers and the International Brotherhood of Firemen and Oilers, represent approximately 23 percent of the employees at Michael Reese Hospital in Chicago. Martin Oscadal, director of employee relations, states that aside from one service disruption, the hospital has had no significant problems in its twenty years of working with the unions. "I don't think any management likes to have their work force organized," he said. "It reduces flexibility. Each negotiation is difficult and there is always the potential of service disruption."

While both Ciesil and Gavin report good union-hospital relationships, they agree that the upholding of the eight unit rule would have a positive effect for labor and would lead to considerable expansion.

The outlook for nurses' unionization

The outcome of the suit will also influence organizing by the Illinois Nurses Association (INA). In Chicago that union currently represents nurses at University of Chicago Hospitals, University of Illinois Hospitals, and Cook County Hospital.

Nurses at the University of Chicago Hospitals have been unionized since the early 1970s. Carolyn Smeltzer, R.N., F.A.A.N., vice president of nursing, reports that when she makes rounds with the nurses they communicate on professional issues with "no hint of unionization. We're all here to give effective care." She assigns this good working relationship to the union's having been in place for more than fifteen years. At the same time she sees the union as standing in the way of quick decision making on issues like the distribution of grant monies. "Without the union," she said, "I could be more responsive to the nurses on certain issues that now take me three to six months to negotiate."

Smeltzer sees recent efforts at cost containment by hospitals as one reason why nurses seek unionization. "Nurses think there is an economic inequity in terms of their work and what they're being paid," she said. The shortage of nurses gives them leverage. Also, Smeltzer believes, hospital administrations have not been creative in increasing flexibility in scheduling and benefit choices. Nor have they created an environment in which nurses can feel good about practicing nursing. "Nurses want to feel a sense of making decisions and having control over their practice," she said. She advises hospitals that wish to avoid unionization to keep communication open, "listen and respond."

New hospital targets in 1989

This year the INA targeted two private hospitals for unionization. On April 19 the union filed a petition seeking to represent an all-nurses' unit at West Suburban Hospital in Oak Park. According to Roger Brice, of Sonnenschein Carlin Nath and Rosenthal, attorneys for the hospital, the administration had an NLRB hearing set for May 11 when the board announced its new rules. The hearing has been postponed due to the AHA suit. "Right now, West Suburban doesn't even know if there's going to be an election concerning the nurses union," Brice said. "If Judge Zagel decides the new NLRB rules are not valid, the union could very well withdraw their petition."

In the past, nurses have most commonly been organized as part of larger professional units. The eight unit rule authorizes three separate professional units: a nurses' unit, a physicians' unit, and a unit for other professionals.

"We don't have a lot in common with other professionals like dieticians, librarians, financial people, and physical therapists," said Susan Bennett, R.N., program director for the Illinois Nurses Association. "They aren't always as motivated to be organized as we are." She sees the nurses union not as an outside third party but as a way for the nurses to organize and represent themselves. "The biggest benefit of being unionized for nurses," she continued, "is that they get to speak for themselves. The organized nurses in Illinois have set the standard for what salaries and benefits for nurses are going to be."

In response to INA activity at West Suburban, J. Kevin O'Donoghue, M.D., president of the medical staff, said in a statement, "Electing a union would not improve staffing ratios or enhance continuity of care. Only staff nurses working in concert with physicians and management can address these issues effectively."

Another effort at organizing nurses is underway at Northwestern

(continued on page 9)

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Unions

(continued from page 8)

Memorial Hospital. Lawrence L. Michaelis, M.D., senior vice president for medical affairs, said, "A nurse has to act autonomously and be able to make some very important individual decisions. I can't see how that fits into a union."

At Northwestern HELP represents 900 food service and housekeeping employees. The Operating Engineers represent 50 employees. "There is a big difference between these and nurses unions," says Dr. Michaelis. "We have good relations but it is a much different kind of relationship. They're not directly involved with patient care."

No inroads for MD organizing

B.J. Anderson, special counsel to the American Medical Association (AMA), doubts the NLRB's eight bargaining unit rule will affect physicians on a broad scale. Even though, if upheld, it would allow for the formation of separate physician unions within hospitals, Anderson says, "It only allows physicians to unionize to the extent they are able to now." First, they must be hospital employees. But they cannot fall within the NLRB's definition of supervisory employee. "Physicians who supervise other employees can't be involved in collective bargaining," she says.

A hospital union of employed MDs currently exists at only one Illinois institution. Residents and fellows employed by Cook County Hospital can become members of a house staff association established in 1974. The majority of the house staff belongs to the union. According to Stonewall McCuiston, Jr., M.D., president, the union grew out of concerns over patient care issues. "At Cook County we have more of a sense of obligation to our patients," he said, "so we have a certain vested interest in having our union, more than other residents at private hospitals where the residents seem to be more passive."

In 1985, attending physicians at Cook County petitioned to form their own separate union, but the Local Labor Relations Board ruled against them, saying the physicians were supervisors of residents, and therefore classified as management. "The board decided the physicians couldn't have their own union," said Sharon Wells, board hearing officer.

Agnes Lattimer, M.D., medical director of the hospital, points out that most employees at County, including the nurses, are union members. "In the main," she said, "I think that relationships with unions simply codify the kinds of relationships that are to exist between employees and employers anyway. The hospital has not had a great deal of difficulty with the unions." Problems she has encountered in working with the HSA have involved grievance procedures and moonlighting rules.

At present, downstate hospitals are not experiencing any attempts at union organization. Harvey Lightbody, vice president of Human Resources at Methodist Medical Center in Peoria and consultant to six other central Illinois hospitals, sees the constriction of the health care business throughout the country as creating a great deal of job insecurity for employees. "Employees have to feel confidence and trust in the administration," he said. "If they don't, you are ripe to have the union."

Lightbody believes that the eight unit rule will make it very easy for unions to organize. "The union thing does not scare me," he said. "What scares me is what it would do to a lot of institutions that are having their trials and tribulations right now just trying to survive. It might cause hospitals to close. You can work with one or two unions, but to work with eight, it's an absolute nightmare."

Whatever Judge Zagel's decision on July 20, it appears that hospitals will by necessity continue working and negotiating with unions. According to University of Illinois Hospital director Donovan Riley, "unions are not a deciding factor in the success of a hospital, but serve as constraints on a hospital's ability to manage effectively in an increasingly competitive and fiscally constrained era." ▲

News Capsules

Members in the news

Morgan M. Meyer, M.D., of Lombard, recently received the Elmhurst Memorial Hospital medical staff's Distinguished Service Award for his ongoing contributions and dedication to the hospital. Dr. Meyer is an ISMS past-president, as well as past-president of the Elmhurst Memorial Hospital's medical staff. . . . **Carunguli R. Natarajan, M.D.,** of Olney, recently received a three year appointment as cancer liaison physician for the cancer program at Richland Memorial Hospital, Olney.

David S. Forkosh, M.D., of Chicago, was recently elected a charter member of the newly-formed American Board of Medical Management. Dr. Forkosh is chief executive officer of the Chicago-based FMH Foundation and a fellow of the American College of Physicians. . . . **Michael E. Beatty, M.D.,** of Edwardsville, was recently installed as president of the Madison County Medical Society; **James E. Segrist, M.D.,** of Alton, became vice president; and **Norman Taylor, M.D.,** of East Alton, was re-elected for his 18th term to the office of secretary-treasurer.



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Resident physicians: how the doctors of tomorrow cope today

by Karen Sandrick

THE MEN and women in residencies today face almost all the modern day medical pressures of full-fledged physicians. They have to be efficient in their treatment, getting patients out of the hospital as quickly as possible.

They also need to meet steadily increasing demands for reducing exposure to liability, improving the utilization of scarce resources, and keeping abreast of rapidly changing advances in technology and treatment, in addition to honing their clinical practice skills.

Illinois Medicine recently talked with seven of 1989's crop of resident physicians about their lives—their stresses and financial debts and the difficulties they have balancing professional and personal concerns.

Confronting and coping with stress

Individuals in other demanding professions have dues to pay, but according to Debra Klamen, M.D., a fourth-year psychiatry resident at the University of Illinois, Chicago, medical residents have an inordinately heavy price to pay.

"There are very few other professions that take their toll quite the way medicine does. There have been studies that show some 30 percent of residents have clinical signs of depression in their first year, and other studies show that anger scales go up throughout the internship years," says Dr. Klamen, a member of the Illinois State Medical Society's (ISMS) physician assistance committee, the American Medical Association's advisory committee on physician health and well being, and a recognized expert on the subject of resident stress.

Dr. Klamen acknowledges that the joys of practicing medicine are many. "There is a great sense of personal autonomy in seeing a patient get better and knowing that you had a part in it. Also, the hospital gives you a great opportunity to work with a wide variety of people and practice your trade and skills."

But she emphasizes that residents need to confront stress. "There is always this sense that if you complain about stress, you're not dedicated enough or not a competent physician. So people learn to shut their mouths rather than deal with their stress."

During her residency years, Dr. Klamen has learned to manage stress by "being very efficient, scheduling vacations and performing self-relaxation techniques to keep me on an even keel." She also has cultivated strong social support. She is married to a psychiatric social worker and has numerous other social contacts "so I don't feel I'm out here myself."

A new focus on family life

One of the toughest things for residents to handle, believes Rick Quinones, M.D., is developing solid family relationships while devoting so much time and effort to the residency program. "I'm 30 years old and I'm just finishing up, but it's easier for me because I'm single. My best friend is 31 years old, has two kids, and has two years left. That's tough," says the fourth-year resident in ophthalmology at Michael Reese Medical Center, Chicago.

Dr. Quinones, the son and grandson of physicians, feels that residents today are more concerned about lifestyle issues than previous generations of residents were. "My father is a colon-rectal surgeon who does a lot of surgery. When I was growing up, he would leave every day at four-thirty in the morning to go to the hospital, and he wouldn't get home until seven o'clock at night. Things are different these days because residents don't seem to want to lead that kind of life; they want to be able to spend more time with their families."

Active in organized medicine, Dr. Quinones is a member of the board of directors of the Illinois Association of Ophthalmology and is on an American Academy of Ophthalmology steering committee for young ophthalmologists. He chose to specialize in ophthalmology because "I wanted to be a surgeon, and ophthalmology is one of the newest and most exciting fields of surgery. We can use lasers now to treat patients who otherwise would go blind, to stop the progression of diabetic retinopathy or treat some types of age-related macular degeneration."



Richard Saal

Judith Peters, M.D.

But lifestyle also entered the decision. "Ophthalmology will afford me a lifestyle so I can spend more time with my family when I do have one."

A juggling act

Robert Mitrione, M.D., is a second-year psychiatric resident at Southern Illinois University, Springfield. An "old guy who got the social bug in the '60s," Dr. Mitrione delayed medical school until he could put away a comfortable nest egg.

Married and the father of two children, Dr. Mitrione feels that residents, especially those with families, are bothered most by the inability to control their own lives. "You're accountable for everything that happens. You have to accommodate everybody else's desires and priorities in your schedule, and that puts more wear and tear on you on a daily basis than other things."

He believes that most residents are prepared for the rigors of the specialty training years. "Most folks appreciate at least on a cognitive level the sacrifices that they have to make, that they have to put their lives on hold. But they may not know the extent of it," he states.

Dr. Mitrione points out that "independence is probably the word that suits medical students, residents, and physicians the best. They are good team players in many ways, but they are even better individual players. And they have a lot of dedication, too. I don't think they are just in it [medicine] for themselves."

So while residents may not like "to stay after six o'clock and finish the stuff that has been piling up all day," they endure it because it "enhances their feeling of competency, and it gives them confidence that at least in the end, if not in the interim, they will have more options and be in control."

Money matters—or does it?

Gail Herman, M.D., is well aware of the changes in the way medicine is being practiced these days. A fourth-year resident in internal medicine at the University of Illinois, Chicago,

There is always this sense that if you complain about stress, you're not dedicated enough or not a competent physician.

she is looking into various available practice opportunities and is finding "more group practices and HMOs and less availability of jobs in prime areas."

While job-hunting over the last few months, Dr. Herman has concluded that most residents "can't just go and open an office anymore because it costs too much money. There are some physicians who have been able to do it in small towns. But if you want to stay in medium to large cities, it's virtually impossible."

As Dr. Herman observes, many fourth-year residents are considering temporary jobs in an HMO or a clinic for a year or two, not merely because they can't afford to open their own offices right away. Physicians just out of their residencies need to start paying off their educational debts, she reports.

By the time they leave their specialty training programs, residents have accumulated, on the average, $30,000 in debts. Because the federal government no longer subsidizes medical education, residents have had to seek out conventional loans that have high interest rates and short maturities.

Moreover, while in their residencies, young physicians are able to defer loan payments or make interest only payments. Once they are in practice, physicians need to pay off

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the loans, often in a matter of months.

"I didn't go into medicine for the money; most people didn't. We went into it to help people who are in the ICU or who are comatose get better so they can walk out of the hospital," Dr. Herman asserts. "And we know that whatever specialty we're in, we will eventually make a decent living."

Still, like most residents, Dr. Herman feels somewhat pressured to "make decent money next year." She notes, "I have a lot of debts to pay, and the residents who are married with children have even more expenses. So we feel we have to go out and start making some money."

Helping kids cope

Thirty-nine-year-old Judith Peters, M.D., did not enter medical school immediately after graduation from college because "I was talked out of it by an advisor who said a woman couldn't be in medicine and have any other life," she recalls.

The first single parent to go through Southern Illinois University Medical School, Dr. Peters is in her last year as a radiology resident, and, with a healthy, happy 11-year-old son at home, she is proving her undergraduate advisor wrong.

Dr. Peters entered medical school in 1982, at the same time her son Jeff started kindergarten. And she freely admits that she couldn't have managed without good child care and financial assistance.

"There is a wonderful day care program that is run in conjunction with St. John's Hospital [Springfield], open 24 hours a day, 365 days a year. So if I had to, I could take Jeff in at 5:30 in the morning and not pick him up until 8:30 at night," she says.



Wm. Daniels/The Photo Partners

Rick Quinones, M.D.

"The dean's office at SIU also helped me borrow money after I quit my job [as an anatomy professor in the medical school] and went without income for three years," she adds.

On her own, Dr. Peters has managed by "planning out as many of the little details as you can so the big things, when they come up, will fall in place."

It hasn't been easy, she admits. "There have been times when I was cross and grumpy and my son bore the brunt of it." But she and her son are working things out jointly. "We go over to the library together in the evening. If he has schoolwork, he takes it along. If he doesn't, he takes a video along and sits in the video part of the medical library watching a movie. That way, I know where he is, and he isn't alone." That's just one of the ways, she says, "we cope together."

Medical training: a long-term investment

Thirty-one-year-old Andrew Basile, D.O., a second-year resident in emergency medicine at the Chicago College of Osteopathy, "always had in the back of my mind the idea of going to medical school." He was forced to wait for several years, however, because "when I was thinking about medical school, it was extremely competitive."

Nowadays, getting into medical school is not nearly as competitive. Applications to U.S. medical schools peaked in 1974, when there were approximately three applications for every slot. In 1988, there were less than two applications per position.

The drop in the number of applications to medical schools has to do with the return for the investment in time and money, Dr. Basile contends. "You can go to law school for three years after college and come out and make the same amount of money as a physician who has had to spend four years in medical school and on the average another four years of residency. In terms of return for your investment, medicine is not as attractive," he concludes.

In his own case, Dr. Basile notes that "even if I were to take one of the top-paying emergency medicine jobs, it will probably be at least five years before I can buy property or start a family. A lot of my friends [who went into other professions] already have a house and kids."

He nonetheless is willing to wait because "when I finish, I will be able to go to any emergency room anywhere in the country and do what I really want to do and what I enjoy."

Fitting into the community

Completing his residency in emergency medicine at St. Francis Medical Center, Peoria, Jack Whitney, M.D., acknowledges that his specialty training has not held any real surprises. "Being a resident was never supposed to be a totally reinforcing experience. It was a challenge that you were supposed to get through."

The difficulties, he has found, have less to do with clinical responsibilities and more to do with responsibilities outside the hospital. "I'm married 14 years and have a new son. I've gone from living in an apartment to living in a single dwelling home and having all the responsibilities of being a homeowner and a member of a community. And the real challenge has been to find time to be a full member of that community."

Dr. Whitney asserts that "when you become a resident, your community is the hospital, you're cut off from what goes on outside that environment. In the past, I always was part of a group of people—my family and my community. But I've moved away from my family and my wife's family, and I'm in a community that I don't have time to educate myself about. What I learn, I learn through the hospital, and that is only a porthole into the community."

Still, after working ten years in Chicago area hospitals as a nuclear medicine technician before going to medical school, Dr. Whitney "felt I had a good understanding of what I was getting into well in advance." And now he finds that "every week just reinforces the decision to stop what I was doing and go to medical school." ▲

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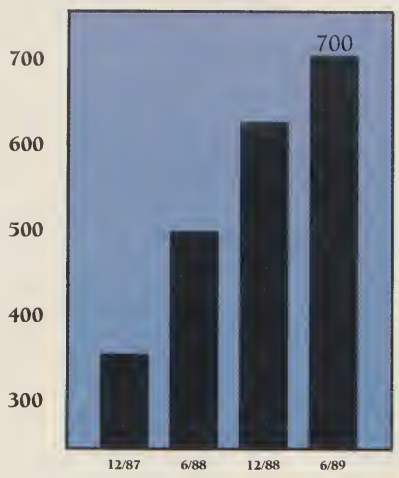
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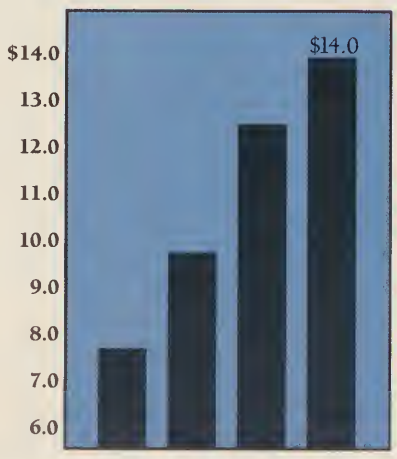
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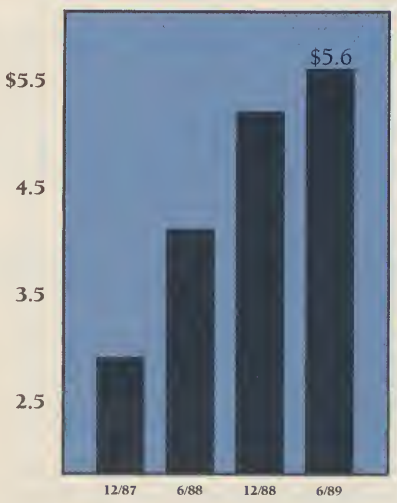
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Legislative Scene

(continued from page 3)

treatment program for pregnant addicted women and addicted mothers and babies has passed both houses. A companion bill requiring addicts to participate in the program also passed both houses, but has been returned to the Senate for approval of House amendments.

A third, related bill that would require providers of pre-natal services to refer substance abusers for treatment has passed both houses. It has also gone back to the Senate for approval of changes made in the House.

Medicare . . . Legislation requiring hospitals to develop procedures for giving 24-hour notice to Medicare Part B patients of discharge from a hospital has passed the House and Senate, as has a bill requiring that Medicare supplemental and non-Medicare health insurance policies covering women over 35 years old include coverage for annual mammograms. Both are on their way to the governor for action.

Social workers . . . Legislation to mandate direct reimbursement of licensed clinical social workers by health insurers failed in the House after winning Senate approval. ISMS had opposed the bill. Proponents attempted to revive the measure by amending it to another bill. However, the move failed after it received only 20 of the required 30 votes. ▲

Medicare delays ICD-9 code penalties

THE GRACE PERIOD for implementing penalties on physicians who fail to use required ICD-9 coding on Medicare forms has been extended indefinitely, according to Illinois' Blue Cross/Blue Shield Medicare Part B program. The extension was achieved through recent joint discussions between officials of the Health Care Financing Administration (HCFA) and the American Medical Association (AMA). HCFA still requires physicians to use the coding. The extension is part of HCFA's agreement to educate rather than apply sanctions as a means to effect compliance. During the extension, physicians who fail to use appropriate ICD-9 codes on claims submitted to Medicare will be exempt from sanctions, denials of payment or referral to the Office of the Inspector General (OIG), according to Kathie Wood, professional relations representative for Medicare Part B.

HCFA is outlining options which Medicare will use in advising physicians not complying with the required diagnostic coding. Physicians should note that Medicare plan administrators will contact them by phone or letter to determine the appropriate diagnostic code. ▲

County Dems

(continued from page 1)

ment of Public Health (IDPH) director Bernard Turnock, M.D., said must be met if the affiliations are to proceed without disrupting care to the medically indigent.

However, by attaching some conditions of his own, Dunne continued the "cat and mouse" game between himself and the General Assembly that has been going on since the University of Illinois Board of Trustees approved the agreements in April.

First, the Illinois Department of Public Aid must provide CCH with a "fair" rate of ICARE reimbursement. Second, the General Assembly must come up with at least $20 million to renovate the university hospital as a women's and children's center, including the correction of any existing life-safety code deficiencies. Finally, the legislature must also provide an estimated $64 million for construction of a replacement ambulatory care facility at CCH.

Rancorous partisan debate

The frequently stormy debate—at one point Democrat Dunne threatened to evict Republican Carl Hansen of Mt. Prospect from the board room—often had as much to do with long-term partisan animosity as it did the issue at hand. For example, Democrat John Stroger of Chicago, responding to CCH employees who oppose the agreements, said that it was the board Democrats who have traditionally voted for pay increases for CCH employees, not the Republicans.

Stroger also criticized the Republicans for not helping persuade U.S. Housing and Urban Development Secretary Jack Kemp to give shuttered Provident Hospital on the city's south side to the county. Stroger said that despite Republican inaction on this issue, Kemp had already sent a letter to Governor Thompson saying that Provident would be turned over to the state. However, a spokeswoman for the Governor told *Illinois Medicine* that as of June 27 no such letter had been received.

Attempting to forestall the inevitable, board Republicans offered a series of amendments designed to air their objections to the agreements. Commissioner Richard A. Siebel (Northbrook) first tried to delete the Turnock condition that guarantees county employment for the approximately 2,000 current UIH employees. He also offered a substitute resolution to negotiate the acquisition of Provident, contract inpatient care of county patients to area hospitals, including UIH, and demolish CCH and replace it with only an ambulatory care center.

But these and other motions, including one calling for public hearings on the issue, went down to successive defeats. The Republicans were thus reduced to rhetorically assaulting the agreements that Dunne had presented to them nine days before. "Maybe part of the problem is, we have an arrogance of power here that threatens the board and all its employees in such a way as to say . . . we don't need to explain to the taxpayers of the county of Cook what these costs are going to be," said Hansen.

Saying that the board voted more than two years ago to build an 866-bed hospital, Commissioner Joseph Mathewson (R-Winnetka) criticized Dunne for proposing the lease of another 500-bed hospital. "We have failed to look at the overall question of medical care and the overall cost," said Mathewson. "This is a crazy way to make such major decisions."

Issue back in Springfield

So, with only three days before the end of the spring session, Dunne sent the issue, together with his financial demands, back to the legislature where he has maintained it belonged all along. More than two months ago he said that acting before the General Assembly would be "spinning my wheels."

In Springfield, implementing legislation awaited a House/Senate conference committee. And amid unconfirmed but recurring reports that high-level negotiations for the university to assume management of CCH were ongoing, the issue was bound to become a bargaining chip in the end-of-session jockeying over an income tax increase.

Awaiting conference committee action were two bills authorizing the lease of the 500-bed university hospital to the county, forgiving the hospital's construction debt, and permitting non-faculty UIH employees to retain their pensions and seniority when they become county employees.

The Senate amended the bills to require that the university affirm in writing 30 days prior to implementing any of the agreements that the 11 conditions contained in the Turnock report have been met. The Senate Committee on Public Health, Welfare and Corrections failed to pass a similar amendment that called for Dr. Turnock to approve that the conditions had been fulfilled. The version adopted by the full Senate is silent on this provision, but IDPH spokesman Thomas J. Schafer said that, at UI President Stanley O. Ikenberry's request, Dr. Turnock will monitor the university's compliance with the conditions.

Chicago Board of Health concerned

Meanwhile, the UI/Reese/CCH affiliations occupied a major portion of Mayor Richard M. Daley's newly-appointed Chicago Board of Health agenda on June 21. Meeting for only the second time, board members expressed concerns with the impact of the affiliations on care for the medically indigent, with the speed of the decision-making process, and the fact that the university is experiencing a spate of faculty/staff resignations, a point not disputed by university officials.

In a three-page analysis of the affiliations' impact, University of Chicago professor and board member Edward F. Lawlor outlined seven areas of potential concern to the Chicago Board of Health. Of particular concern was the seeming rush to build an ambulatory care center on the CCH campus to accommodate the estimated 100,000 per year increased outpatient visits over the current 400,000.

In his analysis, Lawlor said that "it is not clear that this highly centralized response to the ambulatory care and primary care problems of the poor and medically indigent makes good economic or patient-care sense." Lawlor said that the trend is toward decentralized outpatient care, and "the proposed affiliations may have the effect of structuring the mission and effectiveness of the Cook County public health care system for many years to come." The concern for the Board of Health is that the participating institutions provide critical referral links for the Chicago Department of Health.

Additional litigation

Finally, on June 22, opponents of the affiliations filed a second lawsuit charging that university officials violated the state open meetings act. The suit, filed in Cook County circuit court, alleges that Ikenberry met privately with the university's Board of Trustees on Friday, December 16, 1988, at the University Club in Chicago to discuss the pending affiliation plan. The plan was announced to the public on December 20, 1988. ▲

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Chicago Med School

(continued from page 1)

"I think we need to make decisions that are much more current and much more appropriate to the times," Dr. Falk said. He said the school would be examining a number of options, including affiliations with hospitals in Lake and northern Cook counties. Other options include the possible purchase of an area hospital or the construction of an outpatient facility. "I think what's very possible is the (construction) of a large outpatient facility, which is where medical education is going," Dr. Falk said.

CMS leaves city's west side

After more than 60 years on Chicago's west side, CMS announced in 1974 that it was moving from its 11-story building at 2020 W. Ogden to North Chicago and would affiliate with the then Downey Veterans Hospital. The exceedingly controversial announcement produced the resignations of nine of the school's 10 department chairmen who were also clinical department heads at Mt. Sinai Hospital where CMS residents had practiced since 1967. Newspaper accounts at the time also reported that at least 50 percent of the school's clinical faculty resigned, but that they retained their Mt. Sinai appointments. Mt. Sinai reacted by terminating its affiliation with CMS, although the two institutions reaffiliated in 1987.

In 1984, CMS and Humana Inc., of Louisville, Ky., filed for a permit with the Illinois Health Facilities Planning Board (HFPB) to build a 224-bed tertiary care hospital as the school's primary teaching hospital.



University of Health Sciences/The Chicago Medical School

Plans called for 105 medical surgical beds, 20 pediatric beds, 20 obstetrical beds, 20 ICU beds, 15 rehabilitation beds, 20 mental illness beds and 24 perinatal beds.

On May 30, Circuit Court Judge Albert Green ruled that the HFPB violated its own rules when in 1986 it granted CMS and Humana a permit to build the hospital. Currently, CMS has academic affiliations with Mt. Sinai Hospital and Medical Center and Cook County Hospital in Chicago, and with the Great Lakes Naval Hospital and the Veteran's Administration Medical Center in North Chicago.

The complex four-year litigation concerned the HFPB's granting of the permit based on the "special needs" of medical schools and access to services for the area's "medically underserved." The HFPB wrote in its 1986 letter to CMS that "The State Board found the evidence contained in the record concerning these matters highly persuasive and so paramount in their importance as to outweigh other criteria for which positive findings may not have been made."

Why area hospitals sued

Other criteria refers to whether a new hospital needs to be built at all and it was on this point that area hospitals filed suit to stop the construction. The Condell Group, litigants in the action, included Condell Memorial Hospital in Libertyville, Lake Forest Hospital, Victory Memorial Hospital in Waukegan and Lutheran General Hospital in Park Ridge.

In court documents filed shortly before the May 30 decision the Condell Group contended that the area already had too many hospital beds to survive and that the HFPB did not have the authority to grant a permit. "In granting a certificate of need (CON), the board is essentially required to consider two issues: whether the facility is needed as measured by objective promulgated criteria and whether the particular applicant and project best fulfill that need," Condell argued in court documents.

Condell argued that HFPB rules do not define a "tertiary care facility," nor even recognize such a facility or category of service. Condell also argued that while Humana said almost 60 percent of the new hospital's patient base would be "medically underserved," there is no evidence that a private hospital serving that high a percentage of the medically indigent can survive. Moreover, Condell argued that tertiary care hospitals rely on primary care patients.

One of the problems that CMS has had to confront over the years has been a reluctance of area hospitals to enter into affiliation agreements with the school. Dr. Falk said that only the other hospitals could explain their reasons, but he added "I think it remains to be seen what their feelings would now be with the construction of a university hospital not being an imminent consideration."

Former Victory Memorial Hospital president and long time critic of the construction project Douglas Wasson said that the decision was the correct one. "I am very pleased that the courts have ruled as they have because another hospital in Lake County with the reduced activity in the industry level would have been a real burden for us. I'm pleased that Marshall Falk has made that decision also." ▲

Board Briefs

(continued from page 5)

care program to release a copy of the screens used to evaluate the "medical necessity" of Part B claims. Publication of screens for common medical services such as office and hospital visits, consultations and lab services would greatly assist physicians in determining upfront whether or not a claim submission to Medicare requires extra documentation to support its "medical necessity." The AMA approved the Illinois resolution at its late June policy meeting.

ISMS and the Chicago Medical Society are working with the Illinois Department of Public Aid (IDPA) to help IDPA develop a continuing medical education proposal and a medical quality assurance newsletter. ISMS and CMS are committed to urging use of education rather than physician termination from the public aid program, when considered appropriate by the department's medical quality review committee.

Education, lab regulation

The board, upon recommendation from the ISMS Council on Education and Manpower, updated its policy on "fees of allied health professionals employed by physicians." Contact ISMS for a copy of the new language.

ISMS will sponsor a fall meeting with residency program directors to discuss the workings of new procedures for temporary licensure, especially those for foreign medical graduates. The council has reviewed regulations of the state Medical Practice Act governing residency training programs, visiting physician permits and pre-1985 medical school graduates.

The new rules for Illinois' Clinical Laboratory Act took effect July 1, 1989, but doctors will have until year's end to register their office-based labs with state authorities. For further information, see "On the Legislative Scene" (p 3.), and upcoming editions of *Illinois Medicine.*

Residents and students

New 1989-1990 officers for the ISMS resident physicians section are Chairman Andrew Basile, D.O., River Grove; Vice-Chairman William Todia, M.D., Chicago; Secretary/Editor Ron Matticks, M.D., Springfield; ISMS Delegate Miriam Rodin, M.D., Chicago; and ISMS Alternate Delegate Robert Mitrione, M.D., Springfield.

Medical students have elected Chair JoAnne Micale, University of Chicago; Vice-Chair Abby von Heimburg, Loyola; Secretary/Editor Clayton Cowl, Northwestern; ISMS Delegate Robert Klem, SIU; and ISMS Alternate Delegate Samir Master, Northwestern, to lead the ISMS medical student section.

The resident physicians section has submitted its views on "general guidelines for resident work hours and conditions" to the ISMS Council on Manpower and Education for consideration.

Eighteen Illinois hospitals are participating in the 1989 Illinois "medical education community orientation" program, which matches first and second year med students into summer "externships" at hospitals. The students rotate through departments and offices in the hospital, giving them a view of medicine outside the textbook. They receive a small stipend. The medical student section reported that over 70 students have applied to the program, and 24 have been successfully matched as of early June.

The ISMS medical student, residents and young physicians groups are planning a forum to exchange information on common programs and goals. The medical student section will once again present its popular "Preparing for Residency Interviews" program in early fall.

150th anniversary

The board approved a proposal to celebrate the ISMS sesquicentennial with a variety of membership and public programs mapped out by the ISMS Planning and Priorities Committee. ▲

Orthopedic Surgeons

WISCONSIN: Marshfield Clinic, a multispecialty group practice with over 300 physicians, is seeking BE/BC orthopedic surgeons to join expanding regional centers. Positions available in two locations; one in northwestern Wisconsin within 90 miles of Minneapolis and one, a group practice of 25 physicians, in north central Wisconsin approximately 1 1/2hours from Lake Superior. Communities offer exceptional recreational, cultural, and educational opportunities. Compensation package with starting salary up to $149,100 combined with outstanding fringe benefit package totals in excess of $200,000. There is no buy-in or start-up expense. Send C.V. and references to:

David L. Draves
Director Regional Development
1000 North Oak Avenue
Marshfield, WI 54449
or call collect at (715) 387-5376

Marshfield Clinic

Classified Advertising

Send all advertising orders, correspondence and payments to: *Illinois Medicine,* Twenty North Michigan Ave., Suite 700, Chicago IL 60602. Telephone: 312/782/1654; 1/800/782/ISMS. *Illinois Medicine* will be published every other Tuesday. Ad copy with payment must be received at least four weeks prior to the issue requested. Although the Illinois State Medical Society believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify advertisements at its discretion.

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Positions and Practice

BC/BE pediatrician wanted to join three member pediatric group in Aurora, Illinois. If interested, please call Mrs. Cooke, office manager, for information/appointment and interview. Area code (312) 896-7788.

Family practitioner/GP/DO needed. Excellent practice opportunity, beautiful office. Five minutes from hospital. Salary guarantee plus incentive. For additional information, call collect (815) 795-2122 or (815) 795-4600.

Otolaryngology—Brainerd, Minnesota. Join 20 M.D. multi-specialty clinic. No capitation. No start-up costs. Two hours from Minneapolis. Beautiful lakes and trees; ideal for families. Call collect/write: Curtis Nielsen (218) 829-0354 or 4901. PO Box 524, Brainerd, MN 56401.

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Ob/gyn, endocrinologist, ENT, cardiologist, rheumatology, family practice: Immediate opening in 30 member multi-specialty group. Excellent guarantee. Full partnership in one year or less. Average 60% of collection paid to the physician. Send CV or call: Jerry Cummings, Administrator, Danville Polyclinic, 200 S. College, Danville, IL 61832, phone: (217) 446-6410.

Family practice—hospital sponsored clinic opportunity. Dynamic, growth-oriented hospital in beautiful north central Wisconsin is seeking two family physicians for a new clinic facility currently being constructed. The administrative burdens of medical practice will be minimized in this hospital-managed clinic. The hospital has committed to an income and benefit package which is significantly higher than similar opportunities. Package includes base income, incentive bonus, malpractice, disability, signing bonus and student loan reduction/forgiveness program. All relocation costs will be borne by the hospital. Please contact Dan McCormick, President, Allen McCormick, France Place, Suite 920, 3601 Minnesota Drive, Bloomington, Minnesota, 55435; (612) 835-5123.

Family practice—acute care facility in central Iowa seeks family practitioner to join group. Thriving practice; two clinics with strong hospital support. Call coverage well equipped and have spacious facilities. Call Michael Krier at 1-800-332-0488.

HealthLine Physician Services, affiliated with St. Louis University Medical Center, has full-time opportunities for the following specialties: BC family practice, BC pediatrics, BC or BE internal medicine. Income guaranteed, no capital investment. HealthLine also has part-time/full-time emergency medicine, clinic, locum tenens positions throughout the St. Louis area and nearby central/southern Illinois. Paid malpractice, flexible schedules, no call, no overhead; challenging medicine. Contact: Bill Salmo, HealthLine Physician Services, 3663 Lindell Blvd., Suite 410, St. Louis, MO 63108. 1-800-443-3901.

Wanted—Board eligible/board certified emergency medicine physician to join an emergency department staff which is part of a 200 physician multispecialty clinic in Champaign-Urbana, Illinois; 35,000 annual visits. Liberal fringe benefits and salary lead to equal ownership. Send CV with inquiries to J. Yambert, M.D., Division of Emergency Medicine, Carle Foundation Hospital, 611 West Park, Urbana, IL 61801; 217-337-3313.

Emergency medicine—Dubuque—opening available for qualified individual to join incorporated group of three BE/BC emergency physicians. Unique and enjoyable practice, excellent compensation, complete career opportunities, and highly livable community. Write: NET, PC, c/o Mercy Health Center, Emergency Department, Dubuque, IA 52001, or call Mark Singsank, M.D. (319) 589-9666.

Psychiatrist: Community mental health center in northwest Chicago seeks psychiatrist. Responsibilities include: medication maintenance and follow-up and psychiatric evaluations. Four to nine hours per week available, must include some evening hours until 9 p.m. Available 8/1/89. Bilingual, Spanish/English preferred, but not required. Good position for recent graduate or third or fourth year resident. Contact: Val Nabolotny, Portage-Cragin Counseling Center (LSSI), 4840 W. Byron, Chicago, IL 60641, (312) 282-7800.

Pediatric Allergist (Fellowship trainee also considered) needed to help solo pediatrician, twice a month on a Saturday/weekday with allergy patients. Also needed second pediatrician to join solo practice about one hour from Chicago. Reply to box 2142 c/o *Illinois Medicine,* Twenty N. Michigan Ave., Suite 700, Chicago IL 60602.

OB/Gynecologist: Needed for old, progressive Southern Illinois river town. Minutes from urban amenities. Well-equipped new hospital, local college, high employment, this region is unexcelled. Guaranteed net income. Write or call "collect": Wendell C. Trent, DPA Administrator; Wabash General Hospital; 1418 College Drive; Mount Carmel, IL 62863; (618) 262-8621.

Surgeon: Needed for old, progressive Southern Illinois river town. Minutes from urban amenities, well-equipped new hospital, local college, high employment, this region is unexcelled. Guaranteed net income. Write or call "collect": Wendell C. Trent, DPA Administrator; Wabash General Hospital; 1418 College Drive; Mt. Carmel, IL 62863; (618) 262-8621.

Twenty-nine physician multispecialty clinic located in desirable east central Wisconsin location is seeking board certified or board qualified orthopedic surgeon to round out its services. Lab, x-ray, excellent hospital. Liberal guarantee and benefits. If interested contact D.F. Sweet, M.D., Fond du Lac Clinic, S. C., 80 Sheboygan Street, Fond du Lac, Wisconsin 54935.

Internist or gen. practitioner BC/BE to provide internal medicine services for patients of private ophthalmology practice/surgicenter. Responsibilities will incude pre-op H & P exams, EKG interpretation, and staff employment physicals. Mon.-Fri. No nights. No weekends. No call. Send CV to Carole Melton, Hauser-Ross Eye Institute, 2240 Gateway Drive, Sycamore, IL 60178 or call 815-756-8571.

Dreyer Medical Clinic, Aurora, IL. 65 physician multi-specialty group with offices in Aurora, Batavia, Oswego and Fox Valley Villages seeking bd. cert./bd. elig. physicians as follows: int. med., child psych, Ob/Gyn, ophthal. and peds. Located in Chicago west suburban area of extensive commercial and residential growth, clinic is approximately 70 years old and highly respected. Abundant recreational activities available along the scenic Fox River. Please send information to Box #2144, c/o *Illinois Medicine,* Twenty N. Michigan Ave., Suite 700, Chicago, IL 60602.

Healthline Physician Services, an affiliate of St. Louis University Medical Center, is recruiting for an emergency department medical director and staff physicians at Hannibal Regional; Hannibal, Missouri. Growth oriented program in historic Missouri river town. Good compensation, benefits, paid liability. Part-time/locum tenens also available. Contact William J. Salmo, Healthline Physician Services, 3663 Lindell Blvd., Suite 410, St. Louis, Missouri 63108; 1-800-443-3901.

Antigo, Wisconsin: Seeking director, full-time and part-time emergency physicians for low volume facility located in sportsman's paradise. Excellent compensation and paid malpractice insurance. Contact: Emergency Consultants, Inc., 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Central Illinois: Seeking full-time and part-time emergency physicians for two low volume facilities seeing under 7,000 visits annually. Excellent schedule and competitive compensation with paid malpractice insurance. Contact: Emergency Consultants, Inc. 2240 S. Airport Rd., Room 17, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

Family physician—well-equipped 48-bed rural JCAH accredited hospital is looking for a family physician to round out their medical staff. Modern furnished five room clinic located on hospital grounds provided. Lucrative financial package including guarantee for initial period. Unbelievable income potential. The hospital is located in southeastern Illinois in the midst of the Shawnee National Forest. Excellent area for fishing, hunting, boating, etc. Contact Roby Williams, Administrator, Hardin County General Hospital, P.O. Box 2467, Rosiclare, IL 62982. Telephone—(618) 285-6634.

Family/General Practitioners, Central IL and Chicago area. Correctional Medical Systems has opportunities throughout Illinois, for BE/BC general practitioners for either full or part-time primary care in a correctional institution setting. These positions are based on independent contractor agreements, with one of the lowest cost malpractice options in the state. Current Illinois licensure required. Excellent hours, optional on-call, and all health-care units are supported by 24 hrs. nursing staff. For information, contact: Terry Hosutt, Correctional Medical Systems, 999 Executive Parkway, St. Louis, MO 63141 at 1-800-325-4809. Positions also exist in KS, TN, SC, NC, MD, NJ, DE.

Family Physician. Busy, rewarding two-doctor practice in Central Virginia. Beautiful, friendly rural setting close to urban amenities. Virginia offers the ocean, mountains, Washington, D.C., and a great economy. For more information, call Al Southall, M.D., A.B.F.P., Louisa Family Practice, Louisa, VA at (703) 967-2202.

Cardiologist board certified/board eligible wanted for well established cardiology-internal medicine practice in near southwest Chicago suburb. Both invasive and non-invasive practice. Send curriculum vitae and resume to: Box #2147, c/o *Illinois Medicine,* 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Radiologist. A 6-man group is seeking a radiologist with interest in all aspects of interventional and general radiology. The 450 bed community hospital is located in a suburb of Chicago and the new radiology department houses state-of-the-art equipment including the GE 9800 CT and GE 1.5 TESLA MR unit. Minimum requirements are board certification and Illinois license. Position available immediately. Please send curriculum vitae to Enrique Palacios, M.D., Chairman Radiology MacNeal Hospital, 3249 South Oak Park Avenue, Berwyn, Illinois 60402; (312) 420-1960.

Ob/Gyn-Family Practice-Internal Medicine—A variety of attractive opportunities for BC/BE physicians in scenic Great Lakes communities. Contact Bob Strzelczyk to discuss your practice requirements and these positions. Strelcheck & Associates, Inc.; 12724 N. Maplecrest Lane; Mequon, WI 53092; 1-800-243-4353.

Partner wanted-family practice. Close to Chicago, Rockford and Madison, Wisconsin, in beautiful McHenry County, Illinois. Two-person practice, rural lifestyle, urban opportunities, patient growth. Call William Tortoriello, M.D., Harvard, Illinois; (815) 943-7904.

Student health. New opening for primary care internist, family physician or pediatrician available immediately. Accredited facility provides medical services for 18,000 students. Full-time 11 month position. Competitive salary/benefit package and 40 hour week. Illinois license and board eligible/certified. Search continued until position filled. Contact Glenn Weiss, M.D., Student Health Service, Illinois State University, Normal, IL 61761; (309) 438-8655. Women and minorities are encouraged to apply. Affirmative Action/Equal Opportunity Employer.

Family practitioner BC/BE central Illinois for multi-specialty group satellite office in small town. Guaranteed salary with incentive program. Ownership opportunity. Generous corporate fringe benefits. OB/Gyn, pediatric support available. Reply Box 2146, c/o *Illinois Medicine,* 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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Belleville, Illinois—family practitioner and pediatrician: Pediatricians and family practitioners are needed for a pediatric and primary care clinic in Belleville. Visits are scheduled by appointment averaging 25 to 30 patients per day. Clinic hours are 10:00 a.m. to 10:00 p.m., Monday through Friday. Annual reimbursement of $80,000 plus (based on a 45-hour week and physician's performance). High-limit occurrence malpractice insurance offered, allowance for CME, professional dues, state licensing fee and relocation expenses. For complete details, contact Ben Hatten, Spectrum Emergency Care, P.O. Box 27352, St. Louis, MO 63141; 1-800-325-3982, ext. 3004.

Internist—board certified/board eligible. Oak Forest Hospital is an 1100 bed multi-level county institution, located in a suburb 25 miles south of Chicago. The individual we are seeking must be a highly qualified internist, who is available to work a 40-hour week. Excellent benefits and working environment available. Send curriculum vitae and obtain application in confidence through Oak Forest Hospital, Medical Administration Department, 15900 S. Cicero Avenue, Oak Forest, IL 60452, (312) 687-7200, extension 1030.

Anesthesiologist—BE/BC needed immediately to join one MD and one CRNA at 150 bed hospital, located in pleasant suburban community of N.W. area of Illinois. Excellent salary for first year leading to "fee for service." Interested candidates send CV to: Box 2148, c/o *Illinois Medicine,* 20 N. Michigan Ave, Suite 700, Chicago, IL 60602.

Energetic general internist/family physician wanted for rural community. Modern, progressive, well equipped and staffed JCAHO hospital. Excellent physician relations. Attractive remuneration package. Serious candidates only. No agencies. Submit CV to Marvin Schmidt, M.D., or Norman Reynolds, Adm., Mason District Hospital, P.O. Box 529, Havana, IL 62644; tel. 309-543-4431.

Neurologist—board certified/board eligible. Oak Forest Hospital is an 1100 bed multi-level county institution, located in a suburb 25 miles south of Chicago, which specializes in chronic neurological diseases. The individual we are seeking must be a highly qualified, academically-inclined neurologist who is available to work a 40-hour week. Excellent benefits and working environment available. Send curriculum vitae and obtain an application in confidence through Oak Forest Hospital, Medical Administration Department, 15900 S. Cicero Avenue, Oak Forest, IL 60452, (312) 687-7200, extension 1030.

Large neonatal and pediatric group practice has openings for full and part time board eligible/board certified neonatologists and pediatricians. Our hospital based staff currently serves many metropolitan Chicago hospitals. We offer a competitive salary and benefit program including payment of malpractice insurance. Please send C.V., resume or call John Hylton, Director of Operations: Neonatal & Pediatric Services, S.C., 2115 Butterfield Road, Suite 202, Oak Brook, Illinois 60521; (312) 916-8900.

Family practice opening—Join established family practice clinic near 32 bed hospital. Competitive salary and benefits. Medical support from seven major hospitals with consultation and educational services. Family oriented, supportive community in scenic N.E. Iowa. Contact Richard Phillips, Community Memorial Hospital, P.O. Box 519, Postville, Iowa 52162, (319) 864-7431.

Situations Wanted

Board eligible diagnostic radiologist seeks part-time position in Chicagoland and suburban areas. Call (312) 328-2759 or write Box 6283, Evanston, IL 60204.

Certified family-practitioner seeking part-time positions. Reply to Box 2048, c/o *Illinois Medicine,* Twenty North Michigan Avenue, Suite 700, Chicago, IL, 60602.

Anesthesiologist, BE. Experienced, proficient all types of anesthesia with interest in out-patient surgery and pain management seeking PT/FT-solo or group. Please reply Box 2145, c/o *Illinois Medicine,* 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

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Family practice—Busy northwest suburban practice close to many hospitals, for sale. Suitable for BC/BE family practitioner or general surgeon willing to do some general practice. High income. Available immediately. Reply to Box 2133, c/o *Illinois Medicine,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

Practices for sale: PSL, as exclusive medical brokers, is the largest California based company specializing in practice sales. Our specialized services include appraisals, financing, and physician recruitment. Request our free monthly practice list or contact us for a confidential interview. PSL, Inc., 4122 E. Chapman, #10, Orange, CA 92669. (714) 771-4431.

For sale: two exam room sets in good condition, waiting room furniture, copier, and some ob/gyn equipment. Call (618) 283-4081.

Neurometer with literature and supporting IBM software, rarely used, asking $2500.00. David Block, MD, 217-345-6051.

Used Medical equipment. Examination tables, EKG, ophthalmoscope, otoscopes, copy machine, audiometer and many small items. Call (217) 932-4425.

General and Cosmetic Surgical Practice—Clean surgical practice, established 20 years, extensive referral from local physicians and surrounding communities. Established office, all equipment and furnishings available. Central southern Illinois. Universities, recreational facilities, metropolitan areas all easily accessible. Contact E. F. Stephens III, M.D, P.O. Box 1225, Centralia, IL 62801, (618) 532-9220.

For rent: Attractive medical suites, furnished or unfurnished in prestigious air-conditioned medical building, 6450 N. California (corner Arthur), Chicago, IL 60645. Pharmacy, x-ray, complete laboratory on premises. Spacious waiting room and six days full time experienced receptionist/switchboard operators to handle phone appointments. Large parking lot. Willing to make deals. For appointment call: (312) 764-4000 or (312) 338-5089.

Miscellaneous

$5,000-$60,000: For physicians unsecured signature loans. Available for debt consolidation, investments, tuition, relocations, purchase of medical practices or any need including taxes. Level payments up to six years. No prepayment penalty. For application call toll free: 1-800-331-4952, Dept. 114, Medi-Versal.

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Call for papers: Strategies for Patient Counseling— Health Care Team Communications for Enhanced Patient Relations. A national symposium. For guidelines, write: Continuing Medical Education, Chicago College of Osteopathic Medicine, 5200 South Ellis, Chicago, IL 60615, or call 312/947-3429. Conference date: June 1-2, 1990. Deadline: October 1, 1989.

Carl Whitaker, "The Woodstock Experience: A Brief Therapy Weekend" August 11-12. For physicians and their spouses (limited to twenty couples). CME and CEU credit approved. $375 per couple all inclusive. Write: CME, Chicago College of Osteopathic Medicine, 5200 S. Ellis, Chicago, IL 60615, or call 312/947-3429.

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The Exchange exists for the Illinois physicians it insures. Its priorities are diligent claim management, careful underwriting and fiscal responsibility. A commitment to long-term vision, tempered by flexibility, will ensure stability and help to keep rates down. That commitment is a cornerstone of security for Illinois physicians.

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Illinois Medicine

July 21, 1989

ILLINOIS STATE MEDICAL SOCIETY

Health care legislative highlights . . . 8

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Abortion battle looms for fall legislative debate

THE FALL SESSION of the Illinois General Assembly promises to feature a strong battle between abortion advocates and opponents, in view of the recent U.S. Supreme Court opinion on a Missouri case giving states more power to regulate abortion and enabling them to eliminate state funding for abortions or abortion counseling. The court also agreed to hear this fall a related case from Illinois, *Turnock* v. *Ragsdale,* which could set new precedent for abortion restrictions.

Proponents of legislation optimistic

Commenting on the recent Supreme Court decision, Mary Ann Hackett, president of the 8,000 member Illinois Right To Life organization, said "We're very pleased. For the first time, they have upheld the state's right to restrict abortion." Now, she predicted, "most states will make efforts to get into the legislative arena."

Hackett said that "All the polls show the public is not happy with abortion on demand [and although they] may feel it is suitable in certain circumstances, in 98 percent of cases they're not happy with how it's done."

Additional abortion restrictions will be achieved when state courts hear cases on parental notification and consent, as well as clinic regulation, she predicted. "A regulatory law would require clinics to establish safety and health standards equal to hospitals, which would have a chilling effect on abortion clinics," she said. Clinic regulation would be "a great step forward for the health of mother and baby," Hackett added. In the meantime, her organization plans to continue a "massive" public education program. "An educated electorate will vote to defend life," she commented.

Physicians see continuing conflict

John McLaughlin, M.D., a Joliet obstetrician-gynecologist, said he was "pleased to see the [Supreme Court] ruling," but believes it "will cause

(continued on page 17)



Illustration: Natalie Wargin Design

"HIGHLY SUCCESSFUL" characterizes the fate of Illinois MDs' legislative agenda as state lawmakers closed down their 85th General Assembly in the wee hours of July 1.

While taxes, education and suspense over the U.S. Supreme Court's abortion ruling dominated the forefront of lawmakers' debate, Illinois physicians were able quietly to achieve a wide variety of significant gains, among them the largest public aid reimbursement hike in two decades, repeal of the AIDS premarital testing law and a ban on discrimination against foreign medical graduates.

Below are brief highlights of legislative action. This *Illinois Medicine* also features complete, detailed coverage of General Assembly action on important health care issues.

ISMS policies enacted

Two specific ISMS House of Delegates policies cleared the General Assembly. Legislation banning discrimination against foreign medical graduates incorporates verbatim ISMS policy language stating "The quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education."

A second, 1988 House policy had directed ISMS to "actively work with state legislators to repeal as soon as possible" the mandatory premarital HIV testing law. Having gained General Assembly passage, the bill now awaits Governor Thompson's decision on whether to sign or veto it. The repeal would also apply to premarital syphilis testing.

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$30 Mill Medicaid Hike Ok'd

ILLINOIS physicians will benefit from an average 25 percent rate hike in public aid reimbursements as a result of appropriations approved in the final hours of the legislative session. The new funds stemmed in large part from a $1.2 billion tax increase package passed by state lawmakers.

Almost $30 million in new funding will be allocated to the Illinois Department of Public Aid's (IDPA) budget for physician reimbursements, the largest increase in at least two decades. The physician budgetary allocation rises from $163 million in fiscal year 1989 to $192 million in fiscal year 1990, which began July 1. Funding for the 1991 fiscal year will exceed $200 million.

Every physician treating public aid patients will experience increased

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Public Aid Reimbursement Rates

Routine Office Visit (CPT Code 90040)



*Preliminary projection

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Senior citizens strong lobbyists in mandatory assignment debate

by Caryl Carstens



Hundreds of senior citizens were crowded onto the first floor of the State Capitol in late May, sporting hats, buttons and banners that urged passage of a number of bills their leaders said were of great economic importance to them.

Here and there a sign urged the passage of S. B. 294, legislation that would have required physicians to accept Medicare's "reasonable charge" as payment in full for all Medicare cases. Gerald Prete, president of the Illinois State Council of Senior Citizens Organizations, mounted the platform to urge that seniors work for its passage.

"For you and me, this is D Day, this is the day we get it done," Prete told them. Then he urged them to go up to the third floor where the Senate and House were meeting and tell their legislators of the need for its passage. The council had been telling seniors for weeks that failure to accept Medicare-set rates amounted to an overcharge by their doctors.

When the vote on mandatory assignment came a few days later, on May 26, the House bill never reached passage stage and the Senate bill received only 15 votes. The House bill was consigned to a study committee, which meant the issue was probably dead for the balance of the session.

The issue will return

But one southern Illinois physician is sure the issue will arise again, sometime.

"I think we still have to fight this battle," said William Hays, M.D. of Herrin. Unless there are obvious problems in Massachusetts where similar legislation is in effect, Hays thinks the issue will be brought before the legislature again, and in time will be passed. The economic effect of such a law could result in a major reduction in the availability of medical services, he says.

According to Hays, southern Illinois badly needs an influx of economic activity to produce more jobs. Up to half of his practice is persons on Medicaid or Medicare, he says. What is needed are more patients in private employment who will pay the full fee for medical care.

If southern Illinois' economy remains stagnant, passage of mandatory assignment legislation, "could be the death knell of medical care in southern Illinois," he warns.



Jay Barnard

Sen. Judy Baar Topinka (R-Riverside) (Left) and Sen. Adeline Geo-Karis (R-Zion) were vocal opponents of mandatory assignment.

Hays says he and other physicians in the area wrote or otherwise contacted their Senate and House members to urge a "no" vote.

Legislators report contacts

Sen. James Rea, (D-Christopher), who represents the Herrin area, voted no on the Senate bill. His office reports he received letters and other contacts about equally from the elderly and from physicians.

In contrast, Chicago Republican state Sen. Robert Raica, reports he received up to 700 individual pieces of mail on the issue from elderly voters in his district.

Raica reports that senior citizens representatives are frequently in touch with him, telling him about issues that are of importance to their group. "Quite frankly, despite contacts from ISMS lobbyists, the overwhelming volume of mail I received from senior citizens swayed my vote in favor of mandatory assignment," he said. He voted in favor of the bill.

Jere Freidheim, M.D., one of the Chicago physicians who wrote to Raica, reports the issue was raised at every staff meeting he attended at the hospital where he practices. A pediatrician, he isn't directly affected by mandatory assignment.

He resides in Raica's district.

Dr. Freidheim says he is certain that many other staff physicians also wrote letters to legislators. However, their letters may have gone to other legislators if they did not live in Raica's district, which is on the southwest side of Chicago.

In Lake County, the medical society did special mailings to its members, says Jane Stein, executive director of the Lake County Medical Society. Sample letters were distributed and the auxiliary was recruited to turn out additional letters.

Sen. Adeline Geo-Karis (R-Zion), who represents part of Lake County, says she was personally contacted by two physicians whom she knew. However, she had no letters from other physicians in her district. She voted against the legislation.

Sen. John Davidson, (R-Springfield), reports he received a number of letters on both the Senate and House bills. Davidson, a chiropractor, says he received mail not only from MDs, but from osteopaths and chiropractors. "Overwhelmingly, the mail was in opposition," Davidson says. He voted against the bill.

Sen. William O'Daniel, (D-Mount Vernon), another vote against the bill, credits conversations with the ISMS Springfield lobbying team in securing his vote. He also was approached by one physician from his district.

Daniel Hoffman, M.D. of Mount Vernon reports he and several other physicians also wrote letters to their legislators, but they didn't have an organized letter-writing campaign in Jefferson County.

State Rep. Mike Tate, (R-Shelbyville), asked for and received the reaction of his district's physicians when mandatory assignment legislation was reported out of committee in the House.

"I got overwhelming response to the letter," reports Tate. About half of the doctors in his district responded to his letter requesting their opinions on the subject. He says they not only expressed their opposition to mandatory assignment, but wrote him about other issues with which they were concerned.

Tate's 102nd district includes both rural and urban areas, including the city of Decatur.

Tate says he was opposed to the legislation, but wanted the opinions of physicians actively engaged in the practice of medicine.

"Sometimes we get caught up in this legislative process," said Tate, "and it's incumbent on us to solicit that kind of input."

The legislator said the response of physicians to his survey provided support to the efforts of the ISMS lobbying team.

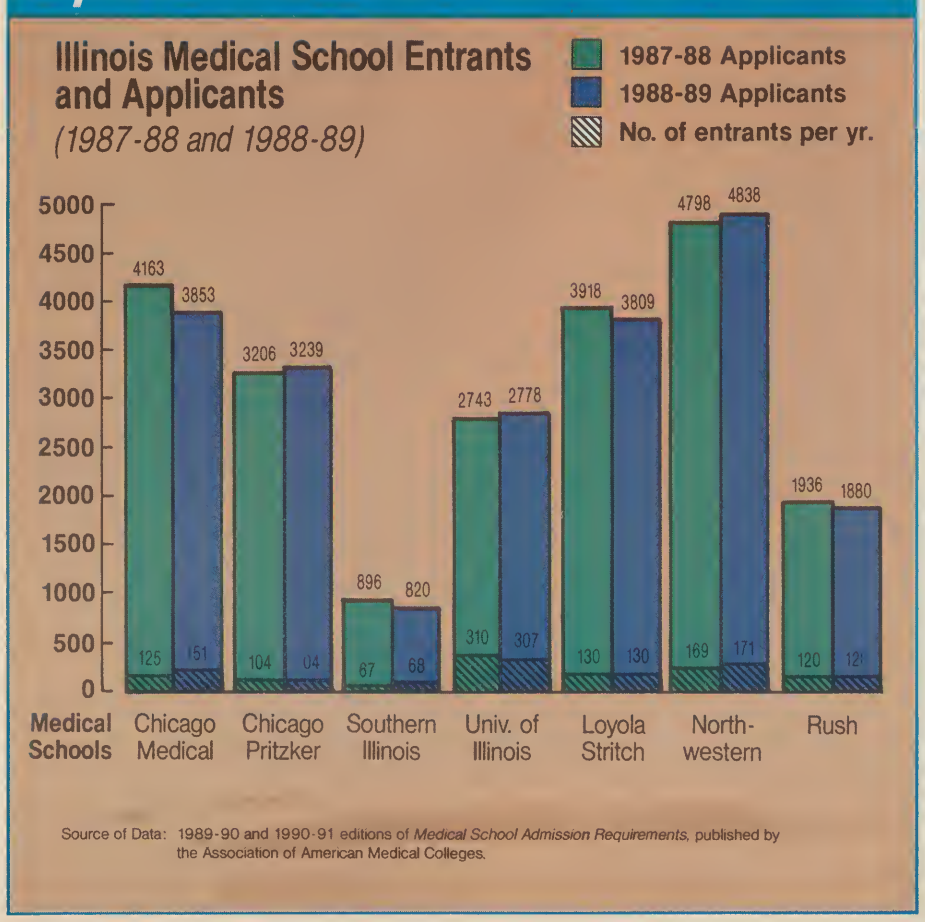
Medical assistants help out

"We really wrote letters and called and did everything we could on it," says Jean Fouts of Bloomington, president of the Illinois Society of Medical Assistants.

The society, whose membership includes the secretaries, office nurses and laboratory technicians who work in physicians' offices, took on the chore of writing legislators, urging defeat of mandatory assignment legislation. The association's executive board put the issue before the council and the members agreed to launch a mass letter writing campaign.

"We really go all out to help the doctors," says Fouts. The group also worked with the physicians during the campaign to pass medical malpractice insurance legislation. ▲

Physician Facts



Source of Data: 1989-90 and 1990-91 editions of *Medical School Admission Requirements*, published by the Association of American Medical Colleges.

ISMS Auxiliary meets with legislators

THE ILLINOIS State Medical Society Auxiliary's (ISMSA) day at the Capitol in Springfield, June 6, was well worth the effort, according to 35 auxilians, representing 10 counties, who attended. "I was pleased with the turnout," said Nancy Hoffmann of Rockford, current ISMSA president. "The feedback was very positive. Everybody felt comfortable and prepared. We really learned something and felt useful."

Auxiliary briefing

Auxilians gathered at 9 a.m. in Springfield for a briefing by ISMS lobbyists on legislative issues needing attention. Lobbyists advised auxilians to thank senators who had voted against mandatory assignment, and to advocate protection of physicians' retirement assets and immunity from liability for physicians provid-

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On the Legislative Scene

by Caryl Carstens



Clean Indoor Air Act . . . H.B. 1695, prohibiting smoking in areas open to the public, was held in the House and will be reconsidered when the legislature reconvenes in October. Under its provisions, individuals would be prohibited from smoking in places of employment, schools, museums and other public places.

In a compromise with the tobacco lobby, certain areas could be designated smoking. As passed by the Senate, H.B. 1695 would also have prevented local governments from enacting non-smoking legislation unless the ordinances were in effect before May 31 of this year.

At first, tobacco industry lobbyists reportedly agreed to the Senate version of the bill, along with the proponents of the legislation. But later, the legislation was criticized by some nonsmoking proponents as being too lenient. The agreement unraveled late in the legislative session. In light of this, prospects are unclear for further action on smoking restrictions.

FMG discrimination . . . Legislation barring discrimination against foreign medical graduates applying for Illinois licensure has sailed through the General Assembly and awaits action by the governor. ISMS had pressed hard for passage of the legislation to prohibit discrimination against any physician "because of national origin or geographic location of medical education."

Drug-addicted babies . . . Helping infants born to drug addicted mothers ranked high on the legislature's agenda this spring. Cocaine and heroin addicted mothers in Illinois gave birth to nearly 2,000 drug affected infants during last year according to the Department of Children and Family Services (DCFS).

Legislation defining infants physically dependent on controlled substances as abused minors passed the General Assembly and awaits action by Governor Thompson. The bill also mandates physicians to refer all addicted pregnant women to the Illinois Department of Public Health (IDPH) for assistance and counseling and requires IDPH to establish a program for pregnant addicts and addicted mothers and their infants.

ISMS opposes requiring prenatal care providers to refer substance abusers to IDPH. "Doctors should work for voluntary treatment of addicted mothers and pregnant women. Compulsory reporting scares them off and doesn't give doctors a chance to guide and counsel them into treatment," explained ISMS President Eugene P. Johnson, M.D.

Ira Chasnoff, M.D. director of the perinatal center for chemical dependency at Northwestern Memorial Hospital agrees. "Physicians must represent the best interests of both infants and mothers. "The best thing we can do is help mothers get prenatal care, encourage them to talk with their physicians and seek treatment for their substance abuse. Legislating such punitive measures will drive women out of the prenatal health care system," he warned.

Mothers could be subjected to civil court proceedings if cocaine traces are found in the newborn's system, under another bill passed by both houses. The bill would allow DCFS temporary guardianship of the affected newborn if traces of illegal drugs are found in the baby's blood.

Dr. Chasnoff supports legal intervention for newborns whose urine tests positive for controlled substances, but are asymptomatic. "Many cocaine exposed infants have no symptoms at birth but are at risk in the next two weeks when they go home and need intensive follow up."

Allied health practitioners . . . None of the legislation aimed at increasing the independent practice of allied health professionals cleared this session. However, several bills remain in committee and could be later revived.

Attempts by optometrists to gain the ability to administer therapeutic drugs failed in committee this session. However, as in the case of optometrists' use of diagnostic drugs, these bills may make a comeback in later legislative debate.

Remaining on the study calendar of the House Consumer Protection Committee is legislation allowing optometrists to be certified by the Illinois Department of Professional Regulation to use therapeutic drugs, in addition to a limited number of diagnostic drugs. The bill never reached the House floor.

The Midwifery Practice Act, allowing for the certification of nurse midwives, also remains on the House Human Services Committee's study calendar.

Legisation establishing qualifications and registration for acupunc-

(continued on page 13)

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

PRO PRIOR AUTHORIZATION NUMBER—BILLING INSTRUCTIONS

Crescent Counties Foundation for Medical Care, the Illinois Peer Review Organization (PRO), recently provided physicians with important information regarding the Preadmission Authorization Program for certain surgical procedures.

Medicare B claims for surgical procedures requiring PRO preauthorization should be filed in accordance with the following instructions.

- **Prior Authorization Number (PAN)** — The PAN is information which must be *shared* by the *surgeon,* the *assistant surgeon,* if there is one, and the *facility* where the surgery is performed. The same PAN must be shown on Medicare claims submitted by these 3 parties for a specific patient.
- **Effective Date** — The information from the PRO was sent to physicians March 16, 1989. The PAN *must* be included on your Medicare claim form, effective July 5, 1989.
- Effective July 5, 1989, assigned claims without a PAN will be denied and non-assigned claims will be developed for the missing information.
- **Billing on the HCFA-1500 Claim Form** — List the PAN in Box 23B "Prior Authorization No." The PRO will provide the physician with a 14-digit number. To bill Medicare, drop the first 2 and last 2 digits, leaving a 10-digit number to be shown in #23B.

  Providers who bill electronically will be sent specific instructions regarding the submission of this information on electronic claims under separate cover.

  Providers who do not accept assignment and instead bill a patient directly by statement or superbill *must* clearly indicate all required information on the patient's bill.

ICD-9 DIAGNOSIS CODING FOR PHYSICIANS

- **Effective date — July 1, 1989.** Physicians were previously informed that a "phase-in" period is in effect. After July 1, an assigned claim submitted without a diagnosis code will be denied; a development letter will be sent to the physician's office if an unassigned claim is received without a diagnosis code.
- "Rule out" codes will not be accepted for payment because Medicare does not cover routine services, such as screening. If the service was not for screening purposes, a diagnosis code will be necessary, showing the highest degree of certainty for the service, such as signs, symptoms, abnormal test results, or other reasons.
- **Be specific** when documenting the diagnosis code(s) on the claim. If a 5-digit ICD-9 diagnosis code most accurately describes the patient's condition, use it!
- Diagnosis coding will be monitored. Educational contacts will be made when a physician fails to use ICD-9 diagnosis coding.

(This report is a service to the physicians of Illinois)

7/21/89

Editorials

Get ready to fight again

At least one accurate conclusion can be drawn from the legislative agenda recently ended in Springfield: health care is one of the hottest topics for the General Assembly's attention now and in the foreseeable future. Judging from the unprecedented volume of bills introduced, it's also apparent that legislators are showing more interest in medicine and health care issues than ever before.

Organized medicine fared very well this session, although medical societies can only be as effective as their individual members' participation permits. Several major issues, including mandatory assignment, were correctly defeated. But they will likely be raised again next session, and we'd better be ready to fight again. For proof of this, read the guest editorial on the facing page.

Of the hundreds of health-related measures introduced, many were actively backed and vocally supported by organized business groups, labor unions, consumer groups, senior citizen organizations and other non-experts in health care. Many proposals lacked a sound medical basis. But, the voices of well-intentioned and active constituents gained the attention of legislators. In some instances, only limited input and contact from individual physicians and other informed professionals left lawmakers with nowhere to turn for a balanced view of the issues.

Now that legislators are again in their home districts, it's vital that individual physicians make a strong effort to establish continuing contact with them, letting them know our views on issues ranging from mandatory assignment, tort reform and indigent care to cost containment measures coming before the legislature. Again, we'll face opposition from groups whose views on health issues differ substantially from our own. But we must be at the forefront in communicating accurate and thorough information to legislators. The future of Illinois health care depends on our acceptance of this important civic and professional obligation.

Rural health crisis can't settle for second best

Dwindling health care in Illinois' rural areas received some well-deserved attention in the state legislature this year. Several measures backed by concerned lawmakers and rural health agencies alike, were designed to encourage health care professionals to practice in underserved areas, and to help residents in these communities gain access to necessary medical attention. These are creditable goals.

But let's view the proposed solutions with a cautionary note. Many concepts for solving the rural health care crisis involve the use of non-physicians to provide care in shortage areas. After all, say advocates, where care is scarce or not available, the gap can be filled with allied health practitioners. This opinion creates a dangerous, "second class" status for patients in underserved areas of the state.

We acknowledge the severity of the care availability problem, but qualifications for providers shouldn't be compromised just to accommodate the shortage. When diagnosis and treatment of a medical problem are required, there is no substitute for physicians' professional skills and training. The residents of rural Illinois are entitled to no less.

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President's Column

ETs: The view across the canyon



Eugene P. Johnson, M.D.

When I look at the concept of expenditure targets as a way to solve the problem of rising health care costs, another image immediately surfaces. It's a view of a deep canyon, with government and the private sector busily widening the gap on one side, while health care practitioners stand on the other side, trying fruitlessly to bridge the increasing divide. And who's in the chasm between? Sad to say, it's our patients, whose access road to adequate care is rapidly becoming impassable.



Illustration: Ken Simpson

If the nation's $600 billion annual bill for health care is unacceptable, the ill-conceived notion of expenditure targets as a "creative solution" proposed by government will be nothing short of a health care rationing nightmare inflicted on an unsuspecting public. Compounding the scenario, the government's plan calls for physicians to make the proposed rationing decisions so that the legislators can abdicate blame for the consequences.

Expenditure targets and rationing will deal a harmful blow to those people who are least able to defend themselves—the elderly and the poor, who are already experiencing difficulty with health care access.

Let's face unpleasant facts: rationing is already an acknowledged factor in American health care.

For prime examples of the disastrous impact on Illinois, just look at the inner cities, where patients who cannot afford to pay for medical care are finding doors closed to them as resources dry up due to inadequate state and federal funding. Look also at Illinois' critical rural health care situation, and the problems patients in small communities face trying to find care.

The access problem is especially serious for a growing number of senior citizens. As physicians, we see that Medicare uses rationing in the guise of ever-tightening restrictions and qualifications on available services elderly people need. And, let's not forget the 30 plus million Americans not covered by any form of health insurance, who ration themselves—and jeopardize their health—by not seeking necessary care because they cannot afford it.

The real problem with ETs is that they introduce a dangerous way of thinking about health care for the elderly, a view alien to physicians and patients. The governmental frenzy to reduce costs redefines what volume of care is "appropriate" and "affordable," in terms of what's favorable to the government's budget. This creates an untenable dilemma for physicians, since we are professionally trained and ethically attuned to providing care that contributes to improved quality of life for the patient, rather than to the enhancement of a budgetary "bottom line."

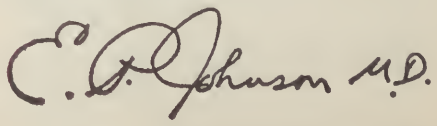
We all recognize that in order to save money and resources, tough decisions about health care have to be made. But who should make them? Under the ET scenario, it would be difficult if not impossible, for individual physicians to make those decisions without compromising quality of care. As physicians, it is important to provide high quality medical care and maintain services regardless of payment, when we agree to provide care.

Accordingly, ET "enforcers" driven by PROs, administrators and other mechanisms would likely be introduced. Once in place, they will prove to be extremely powerful tools solely aimed at meeting the targets for reductions.

We don't need expenditure targets to encourage our own profession to improve cost-effective health care delivery. The AMA and medical specialty organizations strongly support the development of clinically relevant practice parameters that help assure patients of appropriate medical care.

We also have established an excellent track record for improving utilization and quality review, so that services of little or no benefit are eliminated wherever possible. In addition to internal professional efforts, organized medicine is working with the Health Care Financing Administration and other agencies to achieve innovative approaches to quality, practice parameters and utilization review.

If a rationing mentality prevails, the results could be severe reductions in currently available resources and treatment choices. The most negative byproduct will be the deterioration of the quality of care we give our patients. When that happens, politicians will say, "Don't blame us, it's the doctor's decision." We cannot afford to pay that price. ▲



Eugene P. Johnson, M.D.
President

Guest Editorial

Dear Doctor: Why can't we work together?



by Gerald J. Prete

Once again the medical society "beat" the senior citizens in the Illinois legislature. If you're happy about that, doctor, think again.

Remember how we fought about Medicare (the AMA called it "socialized medicine") in the 60's? Your loss then has been your gain ever since. Today Medicare makes up the largest single source of practice revenue for American physicians; yet the elderly now spend a greater share of their income on health care than before Medicare began in 1966.

This session of the General Assembly, your association was able to handily defeat our main effort to protect senior citizens from the mounting out-of-pocket costs for health care—a proposal to require Illinois physicians who treat Medicare patients to accept Medicare assignment.

This legislation means a lot to both of us. In 1987 alone, excess charges beyond the Medicare-determined reasonable rate amounted to $137 million in Illinois. This money comes directly out of the pockets of the elderly and disabled. As you know, insurance companies will not pay those charges. Those individuals who have no insurance pay their own deductibles, co-payments, and overcharges. As of 1988, elderly per capita out-of-pocket health care costs totaled $2,394. This month's *Consumer Reports* says that "excess physician's fees today represent one of the biggest gaps in Medicare coverage."

In 1987 alone, excess charges beyond the Medicare-determined reasonable rate amounted to $137 million in Illinois.

"But we always accept assignment if the patient really can't afford it," you told us and the legislature. Unhappily, this is a myth. Preliminary results of the Physician Payment Review Commission confirm that despite organized medicine's claim to the contrary, low income beneficiaries are not protected from extra billing. We know this to be true since the state council regularly hears from seniors who come to us after being inundated with doctor bills following a stay in the hospital.

But it's not just the poor who are at risk. What about the 90 year old woman from Pekin who had surgery for a corneal transplant? Medicare thought $5,000 was reasonable, paid 80 percent or $4,000, but the bill totaled $17,000. She has a nest egg, but $12,000 makes a big crack in it. Maybe that's a rare case. Still the average non-participating medical practice profits $8200 from excess charges, an amount greater than the annual income of many seniors.

It feels like war, doctor, and that makes me very sad.

And it's not just beneficiaries who are affected. Those companies who pay for health coverage for their former employees are balking at the increases in physician charges. Several major employers expressed interest in the legislation and may soon add their voices to demands for fee limitations.

It feels like war, doctor, and that makes me very sad. Those of you old enough to remember house calls, may also recall the days when family doctors were really the friend of the family. I have fading memories of times when doctors and patients were allies against disease and pain. During the depression, our doctor took care of people knowing it would be a long time, if ever, before he'd get paid. Doctors got respect the old fashioned way. They earned it.

But who needs respect when you have money? Wealth and medicine are more compatible than health and medicine these days. And as physician income has risen, so has the ability of your association to control the political agenda.

What was the secret to your success in defeating Medicare assignment legislation? Are your clever lobbyists responsible? They are certainly capable and savvy people. Or perhaps your persuasive arguments did the trick? Even blackmail can't be ruled out. The legislators were told that you would simply refuse to treat the elderly if this bill passed. Or maybe, just maybe, the real answer was the one blurted out by one senator who said, "If I vote for this bill, the doctors will spend $40,000 to defeat me. Do your seniors have $40,000 to give me?" Politics 101.

But could it be that you've outsmarted yourself? Could it be that you've turned on your most reliable allies, not to mention most lucrative customers. Corporate invaders who view doctors and patients alike as money machines are grabbing for the health care dollar. Wouldn't it be nice to think that you, as health care providers, and we, as the largest group of health care consumers, could travel through these changes together for the benefit of all.

We could start with Medicare assignment. Many of you tell us that the "reasonable rate" is not reasonable. Congress is rapidly moving to address the changes recommended by the Physician Payment Review Commission. Certain specialists will get lower Medicare reimbursements. Primary care physicians and rural doctors will see their allowable fees go up. We applaud that. But if doctors don't accept Medicare assignment, these "reforms" could end up increasing costs for seniors.

Why can't we work together to see that physician payment reform is accompanied by patient payment reform? We're ready to sit down and discuss this issue and other ways to make quality health care more affordable. How about you? ▲

Mr. Prete is president of the Illinois State Council of Senior Citizens' Organizations.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

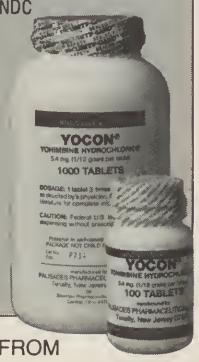
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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MDs make new tort reform gains on retirement assets, standing orders, certificate of merit

by Carol Brierly Golin

Illinois physicians made significant tort reform gains and protected previously enacted tort reforms in the Illinois General Assembly just adjourned.

Certificate of merit strengthened

ON THE GOVERNOR'S DESK

One important bill approved by state lawmakers strengthens requirements for physicians signing certificates of merit required to file malpractice lawsuits. The Illinois State Medical Society (ISMS) worked closely with sponsors Rep. John Cullerton (D-Chicago) and Sen. Howard Carroll (D-Chicago) spelling out strict requirements for physicians certifying that a suit has merit. The measure specifies that physicians must have either practiced or taught within six years in the same area of health care at issue in the case, and must be qualified by demonstrated competence in the same area of medicine at issue in the case. The physician must also have knowledge of the relevant issues in the case. In effect, the new statute mandates certifying physicians be in the same specialty as the defendant.



Jay Barnard

Rep. Tom Ryder, R-Jerseyville (top left), and Sen. Bob Kustra, R-Park Ridge (right), sponsored ISMS caps legislation. Rep. Tom Homer, D-Canton (bottom left), sponsored immunity for physicians' standing orders in public health clinics.

Physicians' retirement assets

ON THE GOVERNOR'S DESK

This legislation, supported by ISMS, protects physicians' qualified pension plans from attachment or seizure in the event that a liability judgment exceeds insurance limits, during bankruptcy proceedings. Sen. Greg Zito (D-Melrose Park) and Rep. Sam Wolf (D-Granite City) sponsored the measure in the final hours after plaintiff attorneys weakened an earlier version.

Standing orders immunity

ON THE GOVERNOR'S DESK

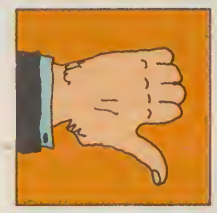
ISMS also supported a bill to provide immunity for physicians writing standing orders for public health clinics. In the final hours of the session it was expanded to apply the standing orders immunity to private not-for-profit clinics providing health care services. Sponsors were Rep. Tom Homer (D-Canton) and Sen. Carl Hawkinson (R-Galesburg). Previously, most physicians writing standing orders were not covered by the state or their professional liability carriers.

Immunity for MDs giving free care

INTERIM STUDY

Plaintiff attorneys successfully beat back ISMS-supported attempts to grant immunity to physicians who provide services without compensation as part of a community-based free clinic. Should true negligence occur, opponents argued, individuals receiving free care would have no right to sue. Efforts to make the bill more acceptable by specifying the kind of clinics and care that would qualify for immunity also failed. However, the legislation was placed in "interim study" and could be revived again in future sessions.

Prejudgment interest



A perennial bill supported by plaintiff attorneys to impose prejudgment interest on all liability awards was introduced by Cal Sutker (D-Skokie), and, this year, reached the House floor. It was returned to committee in the face of almost certain defeat. ISMS again mounted vigorous opposition because of the increase prejudgment interest would mean in award payouts.

Still on the agenda

TABLED

Capping non-economic damage awards at $250,000 remains on ISMS' future legislative agenda, as it failed to attract sufficient votes for passage this year. State Rep. Al Ronan (D-Chicago), who sponsored the caps legislation along with Rep. Thomas Ryder (R-Jerseyville), said, "Very early it became obvious that plaintiff attorneys had total control of both judiciary committees in the House and the Senate." Thus, chances that the bill would emerge from committee were very slim.

Ronan said he is not giving up on the fight. "I have been working on the issue for the last five years with ISMS. We have attempted to enact a cap in the past and we will continue to do so until we have achieved a system that controls medical costs and provides fairness for injured people."

State Sen. Robert Kustra (R-Park Ridge) another chief sponsor, characterized Senate Judiciary Committee Chairman William Marovitz (D-Chicago) as hostile to most medical professional liability legislation. "This year proved to be no exception," Kustra noted. "The bottom line is that it would send a message to the legal community that it cannot prey on health care to extract the major source of its fees," Kustra said. Enactment of caps is more difficult because both Senate President Philip Rock (D-Oak Park) and House Speaker Michael Madigan (D-Chicago) are on record as vehemently opposing it. ▲

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting case and initial diagnosis—A 21-year-old male was brought to a hospital emergency room with a laceration of his arm and contusions and bruises suffered in a fall.

The case in brief—A college student was working a summer job with a salvage crew for a demolition company. He fell in a building that was being demolished. The emergency room physician examined the patient and cleaned and irrigated the laceration. He then explored the wound, removing some debris, and ordered an x-ray of the arm. A tetanus shot was administered. However, no radiologist was on duty and the ER physician did not read the x-rays himself. He then sutured the laceration and the patient was released to the care of his father, with instructions that the young man see his family physician for followup care. Two days passed before the patient saw the family physician, who then called for the x-ray. Upon review of the film the family physician observed a 3 cm. by 1 cm. foreign body in the tissues of the mid upper arm at the anterior aspect of the biceps group of muscles. He concluded that it was glass. The family physician contacted the patient and he was admitted to the hospital where five days after the initial injury neurosurgeons operated to remove the glass. During the surgery partial transection of the right median nerve and brachial artery was discovered and repaired. Over the next six months the young man experienced continual problems with the use of his left arm and continued to treat with the neurosurgeons. Seven months later he was readmitted to the hospital where surgery was performed to treat fibrosis of a neuroma on the ulnar nerve. He was discharged with a metal brace for the arm. There was residual loss of sensation and weakness of the hand and wrist.

The resulting claim—The patient sued the emergency room physician, the general practitioner, and the hospital for failure to identify a foreign body left in his arm, delay in treatment that resulted in further nerve damage, and claimed permanent partial disability, affecting his plans to become an architect. The patient was left-handed.

The outcome of the claim—A jury awarded the patient a total of $275,000. The indemnity paid on behalf of the emergency room physician was $95,000. The general practitioner's indemnity was $75,000 and the hospital paid the remaining $105,000.

The points this case makes—Wound problems account for one of six major causes of dollar losses in medical professional liability suits against

emergency room physicians, the American College of Emergency Physicians reports. Soft tissue injuries comprise 8.2 percent of total indemnity and of these, 13.3 percent are related to retained exogenous foreign bodies.

Consultants reviewing this case were critical of both the ER physician and the family physician. The emergency room physician failed to read the x-ray that had been ordered. If there was no radiologist on duty and he did not feel qualified to read the film, he should not have discharged the patient without arranging for someone qualified to review it, consultants said. Nor did the family physician follow up as quickly as he should have with the emergency room physician, consultants noted, adding that the delay also may have contributed to the nerve injury.

Glass is a continuing problem in soft tissue wounds, consultants pointed out, because it can cause severe complications, as it did in the case described. The American College of Emergency Physicians advises that physicians treating lacerations follow these procedures to minimize the possibility that glass or other foreign bodies are retained in a wound:

- —Always ask a patient what caused the injury. If it occurred in a setting in which glass, metal or other debris may have entered the wound, do these things and document each one;
- —X-ray the wound. The argument that only 50% of glass will show up on an x-ray film is not valid, ACEP says. "Glass does show on plain radiographs. Good technique in a plain radiograph will often demonstrate glass regardless of the percentage of lead content. Soft tissue technique and xeroradiographs can increase the percentage of glass foreign bodies discovered," ACEP noted. However, ACEP also said absence of glass on an x-ray does not mean it is not there;
- —Irrigate the wound if it is possibly contaminated by a foreign body, to minimize possibility of infection;
- —Explore the wound carefully. "Point out to the patient that you have explored the wound and found nothing abnormal," ACEP advised.
- —Explain to the patient that everything possible has been done to assure that no foreign bodies remain, but tell the patient that it is still a possibility; and
- —Advise the patient to seek additional care if any complications develop, and describe what those complications might be. Give instructions in writing.

Consultants also said that there was lack of coordination and communication between the emergency room physician and the family physician and this became a factor in the resulting injury. Better follow-up systems in both the emergency room and in the physician's office would minimize the likelihood that similar delays in diagnosis and treatment might occur. ▲

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AXID®
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Brief Summary
Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.
Axid is indicated for maintenance therapy for duodenal ulcer patients at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.
2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.
3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.
Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.
Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.
Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.
Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.
In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.
Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.
Pediatric Use — Safety and effectiveness in children have not been established.
Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.
Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.
Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.
CNS — Rare cases of reversible mental confusion have been reported.
Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.
Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.
Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.
Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.
Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.
Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 900 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.
Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.
If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

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Additional information available to the profession on request.

85th Illinois General Assembly; Health care highlights



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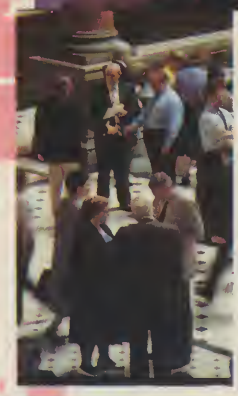
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Ginny Lee







Legislation	*Action*	*ISMS Position*
25 percent average public aid increase	Passed	Supported
FMG discrimination prohibition	Passed	Supported
Mandatory Medicare assignment	Failed	Opposed
Certificate of Merit from physician knowledgeable in same area of medicine	Passed	Supported
Repeal of mandatory premarital AIDS test	Passed	Supported
Mandated written consent for HIV testing	Failed	Opposed
Immunity for public health standing orders	Passed	Supported
Eligibility for exemption from service occupation tax	Passed	Supported
Clinical Lab Act application deadline delay	Passed	Supported
X-ray accreditation for office-trained technicians	Passed	Supported
Use of therapeutic drugs by Optometrists	Failed	Opposed

Perspective

(continued from page 1)

On the liability front

While capping non-economic damage awards in medical malpractice actions continued to elude Illinois MDs, the General Assembly did sign off on several less visible but clearly significant reforms.

The physician-signed certificate of merit needed to file malpractice lawsuits was bolstered to mandate MD expertise in the defendant's specialty. Physicians serving public health and private not-for-profit clinics were granted immunity for standing orders. However, the General Assembly balked at giving immunity to physicians caring for indigent patients in free clinics and sent the bill back to committee.

Physicians' retirement assets will be protected from liability judgements exceeding insurance policy limits under legislation awaiting Governor Thompson's signature.

Medical economics

New tax dollars paved the way for a much-needed Medicaid reimbursement increase to physicians, hospitals and long term care facilities. Injecting monies into the troubled system is viewed by health providers and public health experts as key to solving access problems for indigent patients.

The Illinois Senate flatly rejected another measure which could have created health care access problems for the state's senior citizens. Mandatory assignment is dead for this year, but certain to be resurrected for continuing future debate.

A complex scheme to make physicians responsible for paying state sales tax on products and supplies used in treating patients was altered to exempt most MDs from its impact. But potential back tax liabilities remain unaffected.

Left undone

The U.S. Supreme Court's abortion ruling, announced just after the General Assembly's adjournment, gives state lawmakers and camps on both sides of the issue time to stake out positions and organize for a full fledged battle this fall. Debate on whether and to what extent the state should restrict abortions is apt to dominate the General Assembly's veto session, which begins October 4 and runs approximately 3 weeks. Governor Thompson has called for public hearings to air the issue prior to legislative consideration.

Senate President Phil Rock (D-Oak Park) and House Speaker Michael Madigan (D-Chicago) are both pro-life, but remain silent on whether they will call the abortion related bills for October debate. Stalling on the issue could prevent legislators from going on-record on abortion, and presumably protect incumbents from attracting opposition in March party primaries.

Backers of the Clean Indoor Air Act hope to regroup and resurrect their measure restricting smoking in public places for reconsideration this fall. This perennial legislation came close to enactment, but support crumbled when a compromise with tobacco lobbyists fell apart. ▲

Legislature repeals premarital AIDS testing law

ON THE GOVERNOR'S DESK

REPEAL OF the law requiring Illinois marriage license applicants to be tested for human immunodeficiency virus (HIV) was among AIDS bills debated and passed by both houses this session, then sent to the governor. While Governor Thompson "has not yet taken a position on that bill," according to spokesman Jim Bray, "the governor over the next several weeks will review what Illinois' experience has been with the testing law and hear more on both sides of the argument."

The Illinois Marriage and Dissolution of Marriage Act was amended January 1, 1988 to ensure marriage applicants are tested for HIV antibodies and advised of the test results.

A coalition of public health officials, physicians and state legislators fought an all out battle to repeal the law requiring premarital testing.

"The Illinois State Medical Society (ISMS) played a very key role in that effort and deserves much of the credit for correcting that particular misstep of the state legislature two years ago. It was the influence of ISMS which really carried the day," said Bernard J. Turnock, M.D., state public health director.

ISMS president Eugene P. Johnson, M.D., explained the organization's opposition. "Spending time and such an extraordinary amount of dollars on a population that is without high risk behavior and yields such low HIV positives is medically inappropriate. Energy and dollars need to be re-routed into AIDS education to prevent other populations that engage in high risk behavior from spreading the HIV," he said.

"I tried to repeal it right after it passed because the public health people were united in believing it to be clinical busy work," agreed Rep. Grace Mary Stern (D-Highland Park), sponsor of H.B. 18, repealing premarital AIDS testing. "But on the other side, it was said, 'We just passed this bill. Leave it in effect for a year and let's evaluate what we get.' That wasn't unreasonable. After it had been in effect for a year, I thought we had statistical evidence that we were doing something unfruitful."

Ineffective and costly

Ineffective and costly top the list of arguments favoring repeal of the law. To date, only 45 of 230,000 people planning to marry tested positive according to the Illinois Department of Public Health (IDPH).

IDPH spokesman Tom Schafer said the rate of infection for married couples is only one-tenth the overall rate, while gay men account for 73 percent and intravenous drug users make up 11 percent of the state's reported AIDS cases.

"The fact that this program is in the neighborhood of five or six million dollars a year suggests that the General Assembly, if they're serious about this kind of requirement, might well consider putting another five or six million dollars into other AIDS prevention control measures that would be hundreds of times more effective," stressed Dr. Turnock.

Ken Haller, M.D., chairman of the St. Clair County Task Force on AIDS suggested channeling money spent on premarital testing into "setting up education programs or paying for medications which are very expensive for people with AIDS. It also could help establish social programs for people who have lost jobs and insurance from having AIDS."

State is losing money

Loss of marriage license revenue is another concern that spurred repeal of the premarital test mandate. Illinois is the only state requiring premarital testing. Statistics show a large increase in couples marrying in neighboring states to avoid paying the average $35 test cost. Wisconsin's

To date, only 45 of 230,000 people planning to marry tested positive according to the Illinois Department of Public Health.

Kenosha county clerk's office issued 1,142 marriage licenses to Illinois residents last year, compared to 58 in 1987. Indiana's Lake county clerk's office reports a six-fold increase, from 167 licenses issued in 1987 to 1,008 last year.

Because of the overload, Indiana increased its fees for out of state couples from $18 to $60 July 1, according to Lake County's chief deputy circuit court clerk Terry Barczak. "The increase in marriage licenses is not generating any more money to our county so they're not giving us any more employees. We've gotten busy since Illinois started AIDS testing and I don't think it's going to get any better until Illinois repeals it," said Barczak.

Legislators opposing the repeal

Opposing the repeal of the premarital test is Rep. Penny Pullen (R- Park Ridge). "The entire cost of premarital medical exams, which have been mandated for decades, has been laid at the feet of the HIV testing and that's unfair." Pullen said two reasons physicians test for HIV are to properly diagnose when symptoms are present and to control infection with certain high risk populations. "And what the public health community has yet to understand is that premarital testing was never intended to fit those two categories. It was intended only to provide life-saving knowledge to persons who are about to engage in a state sanctioned activity which will transmit the virus if it is present."

Also arguing against repeal of premarital testing is Sen. Virginia MacDonald (R-Arlington Heights). "There is so much risk because society has changed, with premarital associations, living with different partners before marriage. The lives of people who've discovered their partner has AIDS have changed dramatically. How would these people who marry know if they have AIDS, and how can we keep from passing this on to innocent unborn children?"

Pullen noted many physicians don't realize H.B. 18 also removes the requirement for premarital syphilis testing. There were fewer cases of syphilis than there were HIV-infected people last year said Dr. Turnock, noting more than two dozen states have repealed the syphilis testing requirement. "It plays very little role in the control of the disease. There are better ways to control congenital syphilis through prenatal testing."

Repeal of premarital AIDS testing would be replaced by the requirement for brochures available at each county clerk's office. The free pamphlets for marriage applicants would describe sexually transmitted diseases including AIDS.



"Mud" Meister

Rep. Grace Mary Stern (D-Highland Park) sponsored the premarital AIDS testing bill.

Move to mandate written consent fails

Also debated this session and placed in "interim study" was legislation to reinstate mandatory written consent for AIDS testing. H.B. 24 amended the AIDS Confidentiality Act to "delete the provision authorizing a physician to perform an HIV test on a patient who has given general consent to treatment, but no specific consent for the HIV test," according to the bill. Identical to H.B. 24 was S.B. 166, considered by the full Senate and defeated May 17.

Last year, the General Assembly amended the AIDS Confidentiality Act allowing testing for HIV seropositivity without written informed consent in certain conditions. Although physicians are not required to obtain written consent when the HIV test is medically indicated and the patient has otherwise consented to treatment, they still must gain a patient's general informed consent for any diagnosis or treatment and ensure patient confidentiality.

ISMS lobbied for repeal of mandatory written consent last year and opposed H.B. 24 and S.B. 166's thrust to reinstate it. "The physician patient relationship must be built on candor and trust, not government intrusion and bureaucracy. We realize that AIDS, like many other diseases carrying social stigmas, must be treated aggressively and sensitively by physicians. But mandating written consent for HIV testing doesn't guarantee that. In fact, in some cases it could have an opposite effect," said Eugene P. Johnson, M.D., ISMS president.

Phyllis Gerber, M.D., Chicago agreed, saying, "If patients come in and are bleeding, I must render first aid to them. If there is a questionable sexual history and I've been exposed, I think I should be entitled to that information."

But, Rep. Ellis B. Levin (D-Chicago), sponsor of H.B. 24, differed, stating, "This is a disease that has a very substantial stigma attached to it. It is unfortunately too easy to violate confidentiality for information regarding a false positive or positive."

Notifying spouses; knowingly transmitting AIDS

State lawmakers also approved legislation amending the AIDS Confidentiality Act "to allow a physician to notify the spouse of the test subject, if the test result is a confirmed positive and has been confirmed by a more reliable test, provided that the physician has first sought unsuccessfully to persuade the patient to notify the spouse," according to the bill. H.B. 1878 passed both houses July 1 and was sent to Governor Thompson for consideration.

Sponsor of the bill Rep. Pullen says, "This is to counteract how ridiculous the law is to ban a physician from making such disclosures to a spouse. I think it was inadvertent, but it's still a problem for physicians. The bill will also give the physician immunity for acting in good faith."

While allowing physicians to notify spouses, the bill does not mandate physicians take that step.

"Partner notification programs are an important component of the prevention and control effort," added Dr. Turnock. "If this particular statute will assist physicians in playing that role, that would be ultimately beneficial." While H.B. 1878 does not apply to non-married sexual partners, Dr. Turnock noted that physicians can refer infected patients to the state health department for assistance in spousal or partner notification.

The bill also requires the Department of Corrections to provide AIDS testing for inmates upon taking them into custody. Inmates already incarcerated would be tested for HIV as well, and segregated from other committed persons if found to be HIV positive. The bill also requires that prisoners' spouses be notified if the test indicates an HIV infection.

Another bill, also sponsored by Rep. Pullen, makes it a crime for a person to knowingly infect or transmit HIV. H.B. 1871 passed both houses June 30.

"While we certainly believe that it's appropriate to develop sanctions that threaten lives of others through communicable diseases, we must be concerned that we don't abuse this kind of authority that may result in fewer people coming forward for testing and counseling," said Dr. Turnock. ▲

Future service tax relief granted during legislature's last days

by Kevin O'Brien





PHYSICIANS who, beginning January 1, 1990, would have been obligated to collect state and local taxes on merchandise that they transfer through their service or practice were granted some relief in the closing days of the General Assembly's spring session.

However, the legislature's action does not affect physicians' possible liability for back taxes. The accompanying box explains what physicians should do in order to meet the August 15 deadline for obtaining a waiver on interest and penalties.

Last month, the Illinois Department of Revenue sent a letter to taxpayers in all professions announcing that, effective January 1, 1990, it would collect the occupation service tax based on the *selling* price of the merchandise transferred, instead of the *cost* of the merchandise.

Consequently, the onus for collecting the tax will now fall on the service professional, rather than the supplier of the merchandise. In addition, under the old law, merchandise whose selling price was ever 10 percent or more of the service professional's total bill would be subject to separate filing and reporting.

However, due to efforts of Illinois State Medical Society (ISMS) lobbyists and Revenue Department officials, the 10 percent de minimis threshold on the service occupation tax was raised to 35 percent for the medical profession.

Thus, physicians whose merchandise is less than 35 percent of the selling price can continue to pay the tax to their supplier. In addition, physicians may compute the 35 percent de minimus threshold either on the basis of their gross sales, or on a transaction by transaction basis.

"Under the new law, physicians' billing procedures won't change, the way they should pay taxes won't change, and they will be essentially unaffected," said Revenue Department official Darlene Logsdon.

ISMS President Eugene P. Johnson, M.D., complimented the Department of Revenue's sensitivity to the needs of the medical profession. "We are most grateful to the Department of Revenue for working so hard to resolve this issue during the hectic last days of the General Assembly's spring session," said Dr. Johnson.

Physicians who think they will still be affected by the higher threshold will have to register for service occupation tax purposes by January 1, 1990. The Department will be sending a letter in the fall explaining taxpayers' obligations under the law and procedures for registering. *Illinois Medicine* will report on developments in this process as they occur. ▲

But MDs still liable for back taxes—follow these three steps

The General Assembly's change in the de minimis threshold on the service occupation tax does not affect the law on taxes previously due. Therefore, physicians must still determine if they are liable for back taxes, file a return and pay the tax by *August 15, 1989,* in order to be considered for the Department of Revenue's program for waiving of interest and penalties.

The following is a step-by-step procedure to follow in complying with the law. Throughout this process, physicians are advised to consult with their own tax advisors.

- ☐ Check past invoices to determine whether materials or merchandise has been bought from any out-of-state suppliers.
- ☐ Determine whether the out-of-state supplier is registered with the Department of Revenue for service occupation tax purposes. The most reliable method for doing this is to contact your suppliers and ask if they are registered in Illinois. National suppliers will in most instances be registered and charging tax. If they are not registered, then service occupation tax has not been paid.
- ☐ If you determine that no service occupation tax has been paid on your out-of-state purchases, you are probably subject to tax. You should now call the Department of Revenue at their toll-free number 1-800-732-8866 and request the step-by-step for voluntary compliance by medical professionals packet of information. The packet includes step-by-step instructions for computing your tax, appropriate tax returns, and a form for filing an appeal with the Board of Appeals to have interest and penalties waived. ▲

Public Aid

(continued from page 1)

reimbursement, but exactly how much depends upon specific medical services provided. Preliminary allocations show office visit rates growing by 40 percent, increasing the routine office visit reimbursement from its current $12.65 to about $17.70. Obstetrical care, surgi-pak supplies and "healthy kids" followups are all targeted for special increases. A 12 percent across-the-board increase, now under final negotiation, would apply to all services not otherwise boosted by the funding package.

All increases are expected to take effect for medical services rendered on or after September 1.

A good first step in improving access

IDPA Director Susan Suter hopes additional monies will "improve access to care in the communities we serve and encourage more doctors to participate in the public aid program." She also said the new funding will protect "quality health care" for those dependent on Medicaid.

"We don't think this will solve the problem wholesale," Suter added, "but it will certainly help. The package passed this year is a good starting point on access problems."

"The only way we can possibly achieve high quality care is by increasing reimbursement," agreed ISMS President Eugene P. Johnson, M.D., who characterized the new funds as welcome relief for a system stretched to its limit. He said, "This is the best progress we've made on public aid rates in years. ISMS worked very hard to achieve this and we're very pleased."

East St. Louis general practitioner Charles Frazer, M.D. termed the added funds "as certainly an incentive and a step forward. It makes me feel it's worthwhile to do something beneficial [for Illinois' poor]." With approximately 30 percent of his patients dependent on Medicaid, Dr. Frazer thinks the boost in funding is "a good use of tax dollars, especially the cigarette tax."

He added that prompt payment and simplification in requirements for reimbursement would help generate more physician participation in the program.

OB pilot program expanded statewide

Physicians caring for Medicaid patients statewide will now earn an average of $770, as opposed to the current $446. This represents an expansion of IDPA's 1988 pilot program that raised OB care reimbursements in 26 Illinois counties, North Chicago in Lake County and 32 zip codes in Cook County at an initial $3.6 million cost.

Prenatal visits throughout the state will be reimbursed at $28 each—significantly above the routine office visit rate—on the assumption that additional time will be devoted to nutritional guidance and other counseling. There is no limit on the number of prenatal visits covered. Vaginal delivery will be reimbursed at $550, and both low cervical and classic cesareans section at $700. Post-partum care billing is unaffected.

For example, 10 prenatal office visits reimbursed at $280, a vaginal delivery at $550 and the six-weeks post-partum visit at $41.90 would bring total reimbursement to $871.90.

Surgi-pak supplies and "healthy kids"

Reimbursement for "surgi-paks," supplies used in office-based surgical procedures, will rise 20 percent as a result of the new appropriation. Equipment used on a surgical tray and casting materials are two such surgi-pak examples.

IDPA began reimbursing for surgi-paks several years ago to encourage cost containment through use of appropriate outpatient surgery. Before that, physicians were compensated on a flat rate for in-office procedures.

IDPA's "healthy kids" program will see rates for a single followup visit almost triple—from the current $12.65 to $30—due to the new funds. "Healthy kids" covers pediatric care for routine checkups, immunizations and related preventive care to assure the continuing health of IDPA's youngest beneficiaries. The initial screening visit is reimbursed at $30. All other followup visits are unaffected.

"Certainly the 'healthy kids' followup will come close, if not completely cover the costs," said Dr. Johnson. "IDPA is trying to encourage physician participation." He noted that low reimbursement and burdensome paperwork are two big factors dissuading physicians from getting involved in the "healthy kids" program. "Both those seem to have been taken care of," he said. IDPA simplified "healthy kids" billing requirements last year.

A boost in hospital rates, long term care

Illinois hospitals who serve a disproportionately large share of public aid patients will get an additional $55 million in Medicaid monies, with $9 million of that total targeted for children's hospitals. "It helps the hospitals that help us, as well as specialty children's hospitals," said the IDPA's Suter.

Rischer Watts, M.D. a physician on staff at Bethany Hospital on Chica-

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UI trustees agree to keep hospital open and study Reese affiliation; acting department head resigns

by Kevin O'Brien

PROSPECTS UNCERTAIN

THE UNIVERSITY of Illinois hospital will remain open, at least for the forseeable future. At the university's July 13 Board of Trustees meeting, university President Stanley O. Ikenberry outlined three challenges confronting the university in the wake of the Illinois General Assembly's refusal to allow the lease of the 500-bed university hospital to Cook County.

Ikenberry said that efforts will be launched to rebuild consensus within the College of Medicine, review the nature of the university's already approved affiliation with Michael Reese Hospital and Medical Center, and develop a long-range plan to build the hospital's declining patient base. In addition, Ikenberry appointed executive vice chancellor James Stukel to begin the healing process within the university.

Resignation blow to university

Ikenberry's action comes one week after the resignation of Bruce H. Brundage, M.D., as acting head of the department of medicine. Dr. Brundage was named acting head by College of Medicine Dean Phillip M. Forman, M.D., shortly after the affiliation agreements were announced last December. Under the terms of the Reese agreement, the appointment carried an identical appointment at Michael Reese.

In late March, *Illinois Medicine* invited representatives favoring and opposing the affiliations to submit articles in support of their view for a point/counterpoint feature. The university selected Dr. Brundage to submit the article supporting the plan, while the university hospital's medical staff president John L. Skosey, M.D., contributed the article opposing the agreements. Both articles ran in the April 14 issue.

In his article supporting the affiliations, Dr. Brundage said that these "partnerships will give the respective institutions access to the knowledge and expertise of each other's faculties, enhance the education of health sciences students and residents by expanding the scope and diversity of their patient-care experiences and open new opportunities for collaborative research." He called the plan a "win-win-win situation for Chicago, Cook County and Illinois."

Although faculty and hospital sources said that Dr. Brundage's reason for resigning was differences with Dean Forman, Dr. Brundage declined to comment when contacted by *Illinois Medicine*. Dean Forman was unavailable.

Affiliation opponent and former College of Medicine dean Truman O. Anderson, M.D., called the resignation a major loss to the university.

"He's brought real excitement to our research programs, and I think that this is yet another example of the kind of breakage in a real fundamental way that's been occasioned by this disastrous proposal," said Dr. Anderson.

Dr. Skosey said that although he and Dr. Brundage agreed to disagree on the affiliation plan, they maintained cordial relations. "I don't know what Bruce's long-term plans are, but I hope that he will come back and be chief of the cardiology section where he served very effectively before, and where he still has the support of his section and the rest of the department," said Dr. Skosey.



Bruce Brundage, M.D., formerly acting head of the department of medicine at the University of Illinois College of Medicine, Chicago.

Opponents ask for Board of Health study

Meanwhile, community and faculty opposed to implementation of the Michael Reese agreement called on Chicago's new Board of Health President Whitney M. Addington, M.D., to appoint a blue ribbon panel of health care, community and political leaders "to begin forging a comprehensive program that insures all citizens of the metropolitan area equal access to health care resources."

Convening such a group would fulfill a campaign promise of Mayor Richard M. Daley, who vowed to call a summit meeting of state, county and local representatives to study how health care delivery could be more effectively coordinated.

"The Board of Health is, in fact, planning to become more involved in the situation now that the state legislature has taken the position that it has," Dr. Addington said in a phone interview. He said that until the university's Board of Trustees indicates how it plans to support the university hospital, it is premature to convene a special panel to study the issue, although "it might very well be something that happens in the future."

Dr. Addington said the issue would be a major agenda item at its July 19 meeting. In the meantime, he said the department is discharging its obligation to monitor high-risk mothers referred to the University of Illinois Hospital.

Another look at the affiliation

After the General Assembly failed to authorize the university's lease of its hospital to Cook County, Ikenberry issued a statement saying the "affiliation with Michael Reese Hospital and Medical Center will continue, but will need to be re-examined in light of the fact that the University will continue to operate its own hospital." He welcomed the last-minute additional $25 million appropriation to the university to support the hospital's operations.

The Board of Health is planning to become more involved in the situation now that the state legislature has taken the position that it has.

The trustees must decide under what circumstances to continue the affiliation with Michael Reese. Their original resolution, approved in April, made the Reese agreement contingent upon adoption of the conditions in the report on the affiliations' impact, authored by Illinois Department of Public Health Director Bernard Turnock, M.D. The Turnock report said the affiliations with Michael Reese and Cook County must be considered as a package.

Following the legislature's action, Cook County Board President George Dunne told the board that he would no longer pursue the acquisition of the university hospital and would be presenting a plan for the construction of a new county hospital in the near future.

However, it was reported on July 7 that federal authorities are planning to terminate Medicare and Medicaid payments to Cook County on July 18 because of the many deficiencies that were uncovered in two IDPH inspections conducted since March on behalf of the Health Care Financing Administration. If the deficiencies persist uncorrected, they could also affect the hospital's accreditation. ▲

How Public Aid Increases Affect Illinois MDs

Reimbursement Increases Tentatively Effective September 1, 1989

Overall	From $163 million last year to $192 million this year	25 percent average increase
OB	Expands pilot program for comprehensive care statewide	From $446 to average $770
Surgi-pak	Covers supplies for office based procedures	20 percent increase
Healthy Kids	Increases reimbursement for one follow-up visit	From $12.65 to $30
Office Visits*	All office visit rates rise 40 percent	From $12.65 to $17.70 for routine visit (90040)
Across-the-board Increases*	For services not otherwise affected	12 percent increase

* Preliminary projections

Public Aid

(continued from page 10)

go's west side, thinks the new disproportionate share dollars will be helpful. "It's very difficult," he said, "to take care of [public aid] patients without the hospitals being able to welcome them. The closing of hospitals has not helped us keep physicians in deprived areas where we need them." ▲

Rural health bills approved, but lack essential funding

by Mary Delach Leonard

PROSPECTS UNCERTAIN

THE ILLINOIS General Assembly has approved legislation aimed at improving health care services in rural counties.

The bills include such programs as loan repayments for physicians, malpractice insurance reimbursement for obstetricians and grants and scholarships for allied health care professionals in medically underserved areas.

These bills are on their way to Gov. James R. Thompson:

- S.B. 1303 authorizes the Illinois Department of Public Health (IDPH) to award grants for reimbursement of malpractice insurance premiums for family practice and obstetrical physicians who practice in counties designated as medically underserved. The reimbursement would not exceed 50 percent of the premium and the physicians must practice in the county receiving the grant. IDPH would establish procedures and criteria for the awarding and monitoring of grants.

  An earlier version of the bill limited the reimbursement to a maximum of $5,000 and stated that the physician could not refuse to treat a patient who could not pay for service.
- H.B. 1494 creates a loan repayment program for primary care physicians who agree to practice in physician shortage areas for no less than two years. The maximum annual payment would be $20,000 or 25 percent of the indebtedness per year, whichever is less.
- S.B. 1302, the Allied Health Care Professional Assistance Act, establishes an IDPH program for grants and scholarships to allied health care professionals who agree to practice in designated shortage areas one year for each year of credit. Allied health care professionals include nurses, chiropractors, podiatrists, optometrists and physical therapists. Scholarship recipients who don't fulfill their obligation would be required to pay back five times the amount of their annual scholarship grant for each year they fail to serve.
- S.B. 1304 establishes a pilot program within IDPH to award one-time stipends to newly graduated nurses and nurses who relocate to medically underserved counties. IDPH is to study and recommend procedures and the amount of the stipends and report back to the legislature before Jan. 1, 1990.

  An earlier version of the bill would have provided income supplements ranging from $400 to $1,200 for nurses working in communities of less than 10,000 people.
- S.B. 1307 authorizes IDPH to develop and operate a nursing education pilot grant program to pay student loans for nurses who agree to work in a medically underserved area.
- S.B. 1305 allows taxpayers to donate $1 or more to fund community health centers by filling in the appropriate blank on their state income tax returns.
- S.B. 1306, the Rural Health Care Services Improvement Act, allows counties to form regions to provide rural ambulance services under the supervision of Rural Ambulance System Advisory Boards and authorizes IDPH to issue grants to assist counties in providing regional ambulance service.
- H.B. 421, the Illinois Rural Health Act, expands the duties of the center for rural health in IDPH, to include providing information and technical assistance to rural communities. The bill would also require IDPH to analyze payments made to providers of medical services in designated shortage areas to determine whether a special compensatory standard should be applied to them.
- H.B. 698 requires IDPH to establish a program to expand access to comprehensive primary care in medically underserved communities, including financial support and technical assistance to community health centers.

Funding for the bills remains uncertain. Sen. James Rea (D-Christopher), who sponsored the Senate bills, faced stiff opposition in the House to his funding plan.

The Senate package, dubbed "Rx for Illinois," would have been funded by earmarking the 2 percent privilege tax paid by out-of-state insurance companies that do business in Illinois to a medically underserved counties fund. The tax raises about $65 million a year. The bill, S.B. 1301, was defeated by the House.

The funding bill was later attached to H.B. 168 in conference committee. H.B. 168 would permit liquidated damages in agreements between private organizations and students for loans or grants for medical education.

The Senate approved the conference report, which cut funding to $8 million. But the bill lacked enough votes in the House and consideration on H.B. 168 was postponed.

Sen. Rea said he plans to try again during the fall veto session.

"We've already sent the other bills to the governor. We'll try to encourage the governor to go ahead and sign those bills and then come back with the appropriations during the veto session," he said.

"We moved up quite a bit and we only missed by two votes in the House. It passed overwhelmingly in the Senate, so I think we have a good shot at it."

The rural health bills were spearheaded by downstate legislators whose districts face shortages of physicians and nurses, hospital closings and lack of emergency services.

"We were one of the first parts of the state to experience this. Because of our depressed economy and degree of poverty, those kinds of problems are going to crop up here first," said Rep. David Phelps (D-Eldorado), who sponsored rural health legislation in the House.

Phelps represents the 118th legislative district, which includes 10 counties at the southern tip of the state. The average 1988 unemployment rate in those counties ranged from a low of 12.3 percent in Massac to a high of 18.5 percent in Alexander. The state average was 6.8 percent.

The large proportion of patients on public aid—and resulting problems with Medicaid reimbursement—contributed to the closing of two hospitals in the district since 1986 and the loss of physicians.

"People in my district are traveling an hour or more and 60 to 70 miles just to get basic medical attention," said Rep. Phelps.

Sen. Rea, whose district covers most of the same geographic area, said the rural health legislation will make an impact, but the situation will need to be monitored.

"It won't be over with this first package of bills," he said.

Lt. Gov. George Ryan organized a rural health task force of health professionals last year to study ways of improving access to health services in rural Illinois.

"Through many of the measures passed by the legislature, it's clear that our lawmakers share a commitment to health care in smaller communities," Ryan said. "I applaud the task force for developing such a practical agenda and am pleased that the legislation addresses many of the issues and recommendations likely to be contained in the upcoming task force report."

Health care providers say the legislation is a positive step forward, but more is needed.

"As a rural physician, I support anything that will help the rural areas. The situation has become really disgraceful," said James Welch, M.D., Cuba, a member of the rural health task force. "I'm glad for anything—that's my main reaction. When you're starving, a few crumbs are helpful."

Dr. Welch said more definitive action needs to be taken in the areas of emergency medical service and community health centers.

Medicare and Medicaid reimbursement and the state's malpractice climate also remain large obstacles to the improvement of medical service in rural areas, according to Dr. Welch and physicians working in underserved areas.

"I think the Illinois Department of Public Aid needs a complete revamping of funding policies," said Larry Jones, M.D., a family practitioner in Harrisburg. (See related story on Illinois public aid monies, page 1)

Dr. Jones said that because few physicians can afford to accept public aid patients, many people are going without medical service.

"I have been thinking about having some type of free clinic just to take care of indigent patients—com-

(continued on page 13)



Sen. Jim Rea (D-Christopher), who sponsored a package of bills to help rural areas get much-needed attention, represents southern Illinois—including Harrisburg.

Rural health *(continued from page 12)*

pletely ignoring Medicaid reimbursements. It's easier for me to take care of the people with no pay and forget about it rather than try to bill and have bills refused. It's very frustrating," he said.

Legislation to help pay malpractice insurance does nothing to change the malpractice climate in the state, said Dr. Jones.

"Here in Harrisburg, we have now lost two young very productive physicians to Indiana. They can simply go 60 miles across the border into Indiana which has much better malpractice laws," he said.

Dr. Jones said the situation in rural areas won't improve until the state adopts tort reforms, including a cap on non-economic damages.

"I guess I'm very pessimistic because our legislature is full of attorneys and the Illinois Trial Lawyers Association is so powerful in Illinois. I don't see any meaningful change occurring. And I think a direct result of that is the health care of people in rural areas of Illinois is deteriorating further," he said.

Roger Klam, M.D., an obstetrician-gynecologist in Carbondale agreed the malpractice situation is urgent and needs to be addressed immediately.

"I can visualize that in five years there will be no physicians delivering babies in southern Illinois," he said.

Dr. Klam said the bill that would help pay malpractice insurance for obstetricians is a good idea, but won't work unless the physician can accept patients from other counties.

Dr. Klam said scholarship and loan repayment programs should help attract more physicians and nurses, but believes other action needs to be taken including the licensing of midwives and increased status for nurses. ISMS has opposed such independent licensure and practice efforts due to questions they raise about quality of care in high risk medical situations.

Jacquelyn Clement, Ph.D., assistant dean for academic affairs, school of nursing, Southern Illinois University-Edwardsville, said, "I think any effort to assist or provide assistance or incentives for health care providers—nurses, physicians, physical therapists—anyone to go to the underserved areas is a real plus."

But Dr. Clement said third-party reimbursement is the real hope for nurses who have the certification and credentials to practice in independent nurse-run clinics.

Clement, who is a member of the rural health task force, said higher salaries are also necessary to make the nursing profession more attractive. Legislation to provide grants and stipends will go only so far in solving the nurses' shortage.

"It's only half the problem—it won't keep them in nursing," she said.

Other legislators active in the passage of the rural health legislation included Rep. Thomas Homer (D-Canton), Rep. Larry Woolard (D-Marion) and Sen. Vincent DeMuzio (D-Carlinville.) ▲

Legislative scene

(continued from page 3)

turists was also held for additional study in the House Registration and Regulation Committee.

Legislation granting licensed clinical social workers direct insurance reimbursement for mental or emotional treatment reached the House and Senate floors but was defeated.

X-rays in MD offices . . . Also approved during the final days of this session was a bill modifying the Department of Nuclear Safety's standards for accrediting nurses, technicians or other assistants who administer x-rays under supervision of a physician or podiatrist. H.B. 2351 would allow these technical personnel to perform specific radiation procedures without passing an examination, providing that person has two years of experience prior to July 1, 1989 and a letter of assurance from the physician employer that he or she is qualified to administer x-rays under limited circumstances.

State employees health plan insurance . . . The Illinois Department of Central Management Services (CMS) received a supplemental appropriation of $15 million dollars under legislation passed this session to make up for April and May backlogs of payments to physicians from the group health insurance plan covering many state employees.

The legislature also appropriated money to the general revenue fund to cover the insurance program's fiscal year 1990 budget. The revenue fund for the state employees' insurance program amounts to $327 million, which CMS believes will be sufficient to pay physicians servicing state employees for next year.

Registry for head and spinal cord injuries . . . The legislature approved a measure requiring the state's Department of Rehabilitation Services to establish and maintain a new registry and reporting system for head and spinal cord injuries. Patient confidentiality would be maintained and a hospital adminstrator or designee would file the injury reports. The bill also calls for the establishment of an advisory council to develop plans for services to injured persons.

Blood donations . . . Individuals as young as 16 can donate blood under another measure that passed the legislature. Parents must give written permission for their child's donation.

Physician payment for HMO patients . . . State lawmakers approved legislation allowing up to 10 percent of physician services provided through an HMO to be from physicians not on the HMO staff or under contract to it. The patient would pay deductibles and co-payments.

Cesarean sections . . . The state will now begin collecting information on cesarean sections, due to a new measure approved by the General Assembly. The bill requires hospitals to file annual reports with the Illinois Health Care Cost Containment Council on length of stay, cost of cesarean sections and ratio of the hospital's C-sections to total births.

Mammograms . . . S.B. 273 mandates Medicare supplemental policies and non-Medicare accident and health insurance policies to provide coverage for annual breast cancer screening by low-dose mammography for age 35 and older females.

Non-approved drugs . . . H.B. 506 requires IDPH to modify the current definition of "experimental procedure" to include the use of an FDA-approved drug for a purpose other than which it has been approved. Current IDPH regulations under the Hospital Licensing Act define an experimental procedure as the "use of a medical, surgical, manipulative or psychiatric procedure, drugs or devices for purposes of diagnosis or treatment of human subjects who are inpatients or outpatients of a hospital and who are subjects at risk."

Subjects at risk include those persons who "may be exposed to the possibility of injury as a consequence of participation as a subject in any research development or related activity which significantly departs from the application of those established and accepted methods necessary to meet patient needs or which increases the ordinary risks of daily life," according to IDPH.

H.B. 506 also requires that patients involved in experimental procedures or research programs give informed consent. The bill was introduced by Rep. Monique Davis (D-Chicago) in response to a reported incident at Cook County Hospital where it was alleged that unknowing pregnant women were administered the drug Dilantin as part of a hospital approved experimental program. ▲

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ISMS delegates lead AMA meeting on major issues

AT THE June Annual Meeting of the AMA House of Delegates, Illinois' delegation introduced and spoke on resolutions ranging from member transfer reciprocity to medical necessity denials.

Expenditure targets

P. John Seward, M.D., a delegate from Rockford and chairman of the AMA's Council on Legislation, spoke against expenditure targets, the hottest issue at the AMA meeting, calling them "expenditure caps and rationing."

"This proposal is about who lives, who dies and who decides," Dr. Seward said. "Our proper mission is to be patient advocates. There comes a time to say 'no more.' " President Bush is proposing that Congress establish an annual expenditure target, or "ET" for federal health care spending. The AMA opposes expenditure targets because they would force physicians to make decisions about withholding services from patients, and would exacerbate access to health care for those in rural areas and inner cities.

Medical necessity denial

Illinois delegates introduced a late resolution calling for the AMA to pursue release of necessary information so that physicians could comply with Medicare's medical necessity denial/refund law. Unanimously passed, this resolution addressed the problem physicians face when they try to determine what Medicare deems "necessary." The Health Care Financing Administration (HCFA) has not released appropriate information for physicians to comply with HCFA's requirements.

Medicare ambulance service regulations

At its 1988 annual meeting, the Illinois State Medical Society had introduced a resolution asking the AMA to seek changes in Medicare Part B regulations governing ambulance service coverage guidelines, to allow payment for transporting a patient to a facility other than the closest, based on the physician's judgment. The AMA Council on Medical Services Report B (A-89) addressed this resolution and incorporated much of Illinois' testimony and conclusions in the report, calling on physician input into the regulations. The AMA House adopted the report unanimously.

Tobacco product package labeling

The Illinois delegation introduced resolution 72, as directed by the ISMS House of Delegates, asking AMA to introduce federal legislation requiring tobacco product manufacturers to print clearly and conspicuously the Surgeon General's warning on all tobacco products. Resolution 72 passed unanimously.

Medical licensure

Illinois' delegation also introduced a resolution calling for a single pathway examination for graduates of U.S. and foreign medical schools, and another asking AMA to reaffirm the inappropriateness of discrimination against any physician because of national origin or geographic location of medical education. A compromise resolution calling for a study of the impact of the proposed single examination for medical licensure, with a report back to the House at its December meeting, was passed in lieu of the original. The House adopted the anti-discrimination measure.

Impaired physicians

Illinois' resolution 67, called for the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) to mandate the establishment of medical staff committees to assist impaired physicians as a condition for accreditation. The AMA House adopted the substitute resolution, which recognized the importance of early identification of impairment and asked AMA to encourage hospital medical staffs to have provisions in their bylaws to address the physical and mental health of their medical and house staff members.

Improving physicians' image

In Resolution 70, the Illinois delegation asked AMA to study ways to improve medicine's image by using retired physicians to provide free health care. This resolution was first passed by the ISMS House of Delegates at its April 1989 annual meeting. The reference committee and the House agreed to refer the issue to the AMA board for action. This means that once the AMA board studies the issue, it has the approval of the House to take appropriate action.

Another ISMS House-approved resolution calling on the AMA to enhance the image of medicine by responding quickly to unfavorable comments about the medical profession, was amended by the AMA reference committee. The committee recommended that AMA encourage state and county medical societies to monitor the local media for medical information or misinformation and, if warranted, to respond appropriately. The amended resolution was adopted by the full AMA House.

Membership reciprocity

Joseph B. Perez, M.D., of Rockford, introduced a resolution calling on the AMA to review the membership transfer policies of state medical associations, and to develop a uniform reciprocity policy. Some state medical societies (not Illinois) require new members moving from another state to pay full dues, even though they have paid dues in the same year to another state society. The reference committee recommended, and the House agreed, to refer the issue to the AMA board for action.

Patient transfers

Albino Bismonte, M.D., Illinois delegate from Lake County, spoke about trying to educate physicians and the public about the difference between appropriate patient transfers and "patient dumping."

"Dumping the word 'dumping' is not going to dump the word 'dumping,' " he said. He compared earlier efforts by physicians to use the term "professional liability" instead of "malpractice."

Reporting of residents to national data bank

Andrew Basile, D.O. a resident physician from Chicago, spoke on a resolution asking the AMA to work against reporting disciplinary actions taken against residents to the national data bank. Dr. Basile said residents who make mistakes in training should not be reported to the data bank, because "educational errors should stay in the educational arena." Dr. Basile contended that a resident's errors are "mistakes in training and education, and the education system should deal with them." He noted that when the resident's mistake is "not willful or wanton," listing the occurrence in the data bank is "not an appropriate avenue for discipline." He argued that resident training programs provide proper disciplinary remedies. "The program can put you on probation, have you repeat a year, not credit your year, or not certify you to sit for specialty board exams."

Peer review and reimbursement issues

Illinois delegates also introduced resolutions calling for regulation of external review groups and for relief from third-party payors requesting confidential information over the telephone. The AMA House adopted board report KK (A-89) which addressed the external reviewer regulation issue and referred for study and report back at the December 1989 meeting the issue of maintaining patient confidentiality over the telephone.

The Illinois delegation is chaired by George T. Wilkins, M.D. of Madison County. Vice Chairman is Alfred J. Clementi, M.D. of the Chicago Medical Society. ▲

ISMS backs medical licensure equality

Equality in medical licensure and reciprocity were among the resolutions introduced by the Illinois delegation at the American Medical Association's (AMA) House of Delegates annual meeting in June.

ISMS-backed resolution 68, called for a single pathway examination to license graduates of U.S. and foreign medical schools. In lieu of the proposal, the AMA House of Delegates voted to adopt a substitute resolution calling on AMA to study further the uniform pathway to licensure issue and report at its December 1989 meeting.

Speaking on behalf of the Illinois delegation, Fred White, M.D. said, "The 1989 annual meeting of the ISMS House of Delegates adopted an amended resolution which directed the Society to support the concept of a single examination for both US and foreign medical graduates."

ISMS policy states a single path-

(continued on page 15)

Family Practice

Marshfield Clinic, a multispecialty group practice with over 300 physicians, is seeking BE/BC family practitioners to join expanding regional centers. Practice opportunities range in size from single specialty groups of three to multispecialty groups of 25. Positions available in six locations: two in northwestern Wisconsin within 70 and 90 miles of Minneapolis; two in northcentral Wisconsin within 80 and 90 miles of Lake Superior; and two in central Wisconsin within 25 and 35 miles of Marshfield. Full specialty consultation readily available. Positions offer strong economic stability combined with exceptional recreational, cultural, and educational opportunities, Starting salary up to $89,400 with salary in two years up to $113,100. Fringe benefit package outstanding. Send C.V. and references to:

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Marshfield Clinic

(continued from page 14)

way exam would "simplify the examination process, reduce costs by eliminating duplication and have the ability to introduce major changes in examination content such as computerized testing to assess clinical skills." ISMS policy further declares that a single pathway exam would remove the question of discrimination while allowing the Educational Council for Foreign Medical Graduates (ECFMG) to continue certifying FMGs and providing English proficiency tests. U.S. graduates would continue to be certified by the National Board of Medical Examiners.

Physicians testifying before the AMA reference committee for further study of the issue cited several issues that need to be considered before the AMA makes policy on a single pathway exam. Among them: what form the exam will take; other purposes it will be used for; when accredited medical student graduates will be required to take medical boards—before or after graduation; whether the exam will be used to determine progression in the curriculum; and how well the exam will reflect the core curriculum.

"We could technically end up with people having MDs who have not passed the national boards, cannot be licensed, have large debts that face them and cannot practice their profession. We need to work out these situations so we know the impact on accreditation, licensure and the award of an M.D. degree," said Lee J. Dockery, M.D., chairman of the AMA Council of Medical Education, Gainesville, Florida.

Representatives of the AMA Resident Physicians Section also supported further study of the single exam and asked for continued "input into how the exam is written." Among their concerns were, whether use of the national board scores would be used as a criterion for matriculation in the third year or in the selection of residency applicants, how many times the exam can be taken after failure and the criteria for passing the exam.

Proponents of a single pathway exam

Physicians favoring a single pathway exam for licensure testified that the exam is one element among several criteria for licensure and that concerns expressed over format and usage of the exam are distinct from the issue of licensure. Further testimony stated that dual licensure exams have created problems for some states and threaten to create additional difficulties for other states' licensure boards.

"In this society, at this age, when you say separate but equal, it rings a discordant note. The time has come for this single pathway. We hope to take the strength of the national board and the strength of the federation and meld them together. It will put to rest the term 'discrimination,' the term 'separate, but equal,' but will also, I believe, make a better examination for medical licensure," said Bryant Galusha, executive vice president of the Federation of State Medical Boards.

AMA reaffirms opposition to discrimination

Following positive testimony in the reference committee, the AMA House of Delegates voted to adopt resolution 69 introduced by the Illinois delegation. The resolution called for the AMA to "reaffirm opposition to discrimination against any licensed physician because of national origin or geographical location of medical education, to continue to recognize the rights and responsibilities of states to determine the qualifications of medical licensure within their jurisdiction and to ensure graduates of foreign medical schools meet the same requirements for licensure by endorsement as graduates of accredited U.S. and Canadian medical schools," said the reference committee's report to the full AMA.

"Illinois believes that individual states have the responsibility to determine qualifications for medical licensure. Illinois, like many states, has a very high percentage of FMGs. The ISMS House of Delegates reaffirmed our policy that the quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education," said Dr. White, speaking for the Illinois delegation. ▲

Illinois MDs gain AMA posts



John J. "Jack" Ring, M.D., Lake County, was reelected Trustee and Chairman of the AMA Board of Trustees at the AMA June Annual Meeting.



AMA/Joe Fletcher

William McDade (third from left), University of Chicago medical student, was elected to chair the AMA Medical Student Section. He is pictured with the other AMA student officers.



AMA/Joe Fletcher

Neil Winston, M.D., emergency room physician at Chicago's Mercy Hospital was elected to the leadership of the AMA's Young Physician's Section.







AMA/Joe Fletcher

Andrew Basile, D.O. and Bruce Doblin, M.D. (top left), both of Chicago, were elected to the AMA Resident Physicians Section Governing Council. Silvana Menendez, M.D. (left), St. Clair County, accepts an award for leading the largest AMA Hospital Medical Staff Delegation (HMSS). Joseph L. Murphy, M.D. (right), Chicago, was elected to the AMA HMSS Governing Council.

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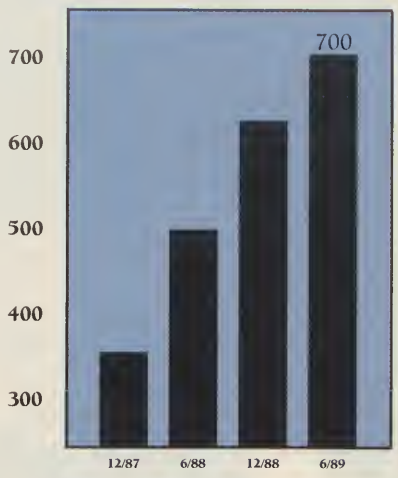
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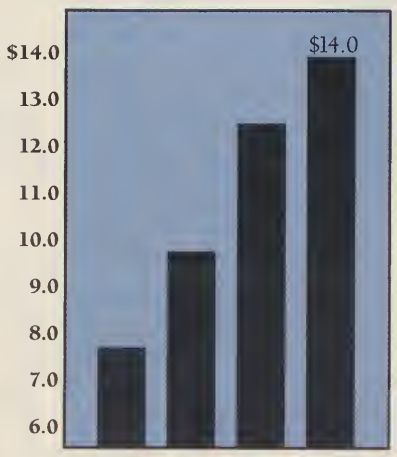
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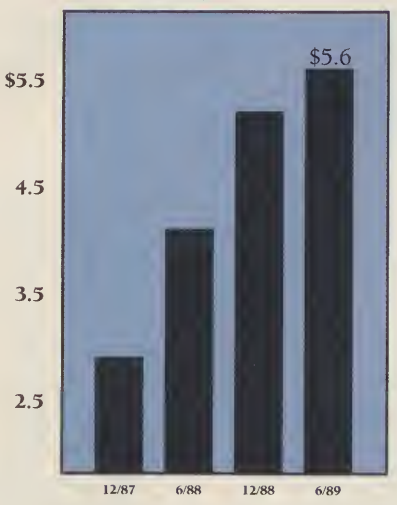
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Turnock v. Ragsdale case puts Illinois in Supreme Court abortion spotlight

An Illinois case is among three on abortion which the U.S. Supreme Court agreed to hear in its fall session beginning October 2.

The case pertains to a Rockford physician who challenged statutory provisions and regulations involving private ambulatory surgical treatment centers. Richard Ragsdale, M.D., sued the state and its public health director, Bernard Turnock, M.D., in 1985 after losing his lease on an existing center and being unable to find a facility where he could relocate without prohibitive rehabilitation costs required to comply with Illinois Certificate of Need (CON) regulations under the Ambulatory Surgical Treatment Center (ASTC) Act. In November, 1985, the district court enjoined the Illinois Department of Public Health (IDPH) from enforcing the Illinois certificate of need law against those physicians who wish to perform first or early second trimester abortions in private facilities. The court said that the certificate of need process "increases the cost and decreases the availability of abortions" and that the state failed to demonstrate any compelling need for application of the process to abortion clinics.

In a March 10, 1988 opinion, the U.S. Court of Appeals agreed, ruling that the CON law's requirements "may not be applied to ambulatory surgical treatment centers that plan to offer abortion services." The state has appealed that decision to the U.S. Supreme court.

According to Daniel Mulvanny, partner with Katten, Muchin and Zavis in Chicago, and former general counsel for the Illinois Hospital Association, "if the Supreme Court upholds the decision, it would be difficult for outpatient facilities to perform abortions without expensive new equipment." Combined with the recent Missouri decision, the impact on abortion in Illinois "could be a double hit. Outpatient facilities may not be available for economic reasons, and the publicly-funded outpatient facilities would be taken out if Illinois were to adopt the Missouri statute."

Mary Huck, public information officer for IDPH said the full impact of attempts to restrict abortions in Illinois "will depend on the action of the state legislature and the outcome of the *Ragsdale* v. *Turnock* case. Until then, we can't say much." Another IDPH spokesman said there are no available estimates on how many abortions are currently performed in Illinois clinics because "since 1985, we've been prohibited from gathering statistics on ASTCs."

In a July 7 Chicago press conference Attorney General Neil Hartigan commented on the recent Supreme Court's abortion decision. "I support the woman's freedom of choice," he said. "The choice may not be one that I would advise a woman to make, but in a pluralistic society like ours, differences of opinion and beliefs must be tolerated and subordinated to the constitutional principles even if the adherence to the constitutional principles conflicts with religion."

As attorney general, Hartigan is charged with carrying out the state's appeal of the Ragsdale case to the U.S. Supreme Court next fall. He stressed, "I committed myself and my office to defend these minimum health standards. It is about protecting the safety and health of a woman who exercises her freedom to choose. I don't believe undermining *Roe* [v. *Wade*] was the intent of IDPH. I can tell you it's not my intent as attorney general. We will make it abundantly clear to the Supreme Court that these rules were not intended to be used in any way to undermine the Roe decision." ▲

Abortion

(continued from page 1)

continuing conflict in Illinois as people try to explore ways to resolve this [problem]." Reporting on patients' comments, he said, "I'm hearing that women are not really pro-abortion. They are in favor of selected abortion when a mother's life is at risk, but they're predominantly not in favor of abortion on demand."

Dr. McLaughlin is "not in favor of abortion on demand," but there has to be a middle ground that has not yet been explored. This is not going to be a popular stand, but like so many things in life, it's not all black or white." He added, "There are some circumstances where the woman's life is at risk [when] I would agree with the need for termination of the pregnancy."

A state senator views the issue

State Sen. Richard Kelly Jr. (D-Hazel Crest), a leading pro-life advocate for many years, sees the legislature addressing abortion next session, via a conference report on H.B. 574, which he introduced in the Senate this year. "From my perspective, I see the legislature trying to enact a decision which would incorporate the Missouri abortion law into Illinois." Predicting Governor Thompson's response, he noted that Thompson "has on several occasions vetoed pro-life legislation, which indicates to me that we're not sure where he'll be if and when we pass a bill."

Kelly is "uncertain we'll have a three-fifths majority [needed for Senate passage], so it would require the governor to be favorable to the pro-life position. He's going to have to be committed one way or another."

H.B. 574 would require that before an abortion is performed on a fetus of at least 20 weeks' gestation, a physician must test whether the fetus could survive outside the womb. The bill also requires physicians who determine that the fetus is viable to perform the abortion at a hospital with life support equipment available for the fetus. Physicians failing to comply could be guilty of a class 3 misdemeanor under state law.

State Rep. Penny Pullen (R-Park Ridge), among the most active legislative opponents of abortion and the House sponsor of the bill, said, "I would seek to re-enact the pre-1973 abortion law which we never repealed, so that abortions would not be performed except to save the life of the mother."

Her constituents are "very supportive, and frustrated at the refusal of the Supreme Court over the years to recognize that the Constitution already has [provision for] right to life in it." She would also like to see the Court "declare that no state could legalize abortion."

She said, "Many of us have a great deal of regard for those heroic medical personnel who work so hard to save the lives of premature babies, and we hope to see the same devotion of the entire medical community to preserving the right of life to all unborn children."

Pro-choice advocates increasingly vocal

Ann Kuta, director of the Illinois Pro-Choice Alliance, a coalition of 34 organizations, helped coordinate a July 5 rally at the State of Illinois Center in downtown Chicago, where a petition to be presented to Governor Thompson, Senator Philip Rock, and House Speaker Michael Madigan was distributed for signatures. "We were there for 13 hours, and received 18,000 signatures expressing support for women's right to choose," Kuta said.

After the July 3 Supreme Court decision, "our offices have been swamped with calls from folks who want to get involved. We're getting offers of money, time and skills. I received calls from people saying, 'I never really believed this could happen. Tell me, how I can help.' "

A downstate physician sees trouble

Suzanne Trupin, M.D., head of the division of OB-GYN at the University of Illinois College of Medicine at Champaign, and a private practitioner in Urbana, views the recent court decision as "a very negative move." She is also troubled by it in light of severe lack of access to prenatal care in downstate Illinois. "We get patients daily who lose insurance, are unable to pay for prenatal care and can't find a doctor. I see dilemmas they face in not being able to get adequate care for whatever choice they make. It's a terrible position for women of this state."

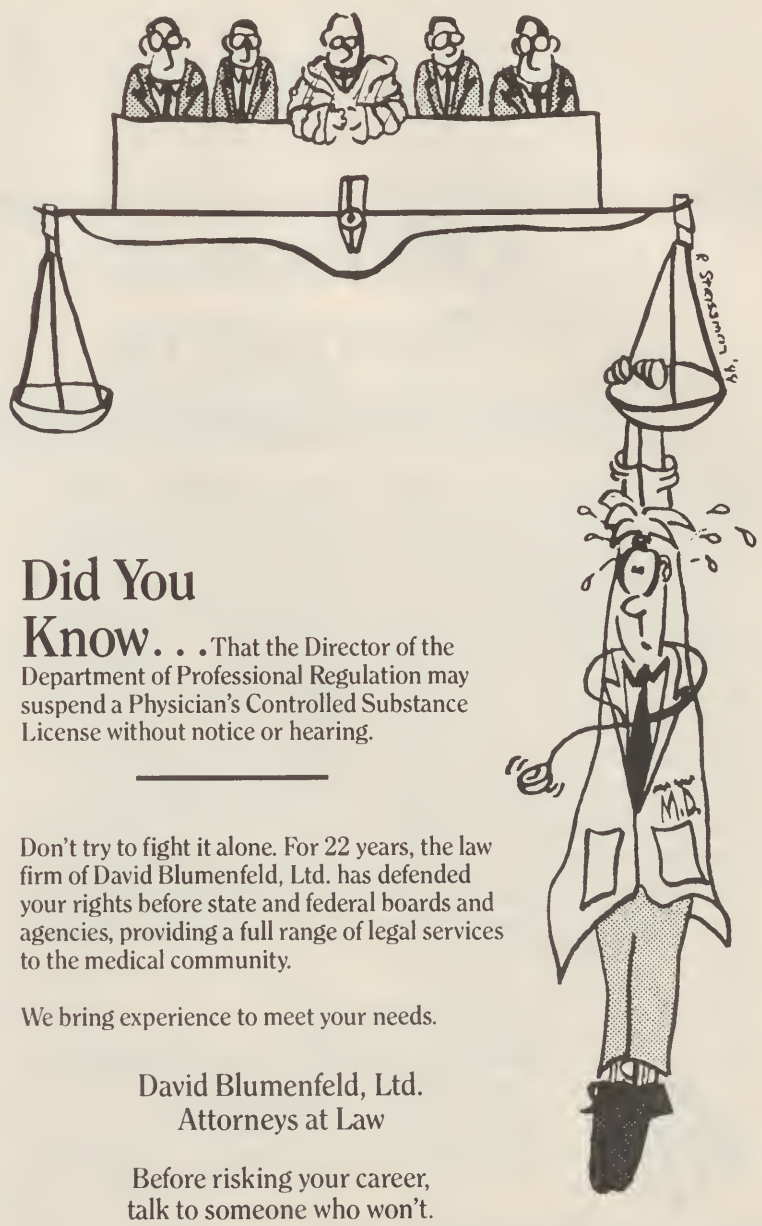
She continued, "I certainly hope for a return to ethicism in medicine and the removal of any [physicians'] biases from the care of women."

Dr. Trupin foresees no exacerbation of the abortion issue downstate as a result of the Missouri ruling "for the next six months to a year, except for a few women who sought care in the St. Louis region. But, if pending rules in the legislature do get enacted, potentially, abortions won't be an alternative in Illinois."

State rep sees "battleground"

Rep. Barbara Flynn Currie (D-Chicago) predicts Illinois will be a "battleground" as opponents on the abortion issue fight it out. "I'm hearing from constituents and the majority of them are asking me to stand for the right of choice." She believes the recent Supreme Court ruling is "handwriting on the wall", which will

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Abortion

(continued from page 17)

"give a reason for the pro-choice movement to mobilize and move the issue off the political back burner to the front of the legislative agenda."

ACLU attorney comments

Attorney Colleen Connell, director of the American Civil Liberties Union (ACLU) Reproductive Rights Project, branded the court decision "bad news for women and bad news for physicians." She said the issue creates a problem for doctors because "it interjects the state into the process of medical decision-making."

The Supreme Court decision also "set the presumption of fetus viability at 20 weeks—four weeks prior to previous, uncontradicted medical testimony setting viability at 23½ to 24 weeks," she continued. "There is no other medical procedure in which the state attempts to second-guess or interfere with the medical judgment of the physician."

The ACLU is providing legal counsel to Rockford physician Richard Ragsdale, M.D., in cooperation with his private attorneys, in preparation for the Supreme Court hearing of the *Turnock* v. *Ragsdale* case. Connell believes that if more stringent state regulations and restrictons on abortion result, women will "return to those days when abortion was only available to the rich or those willing to risk their health and lives at the hands of back-alley practitioners, many of whom were not professionals." ▲

Auxiliary

(continued from page 2)

ing care in free medical clinics. Background was also provided on the Clean Indoor Air Act and the attempt to provide for direct insurance reimbursement to clinical social workers. Sen. Bob Kustra (R-Park Ridge) provided the group with insights into what elected officials need from constituents to serve them better. Following lunch, auxilians had two hours to visit with individual legislators.

"I was impressed with the whole day," said auxilian Barbara Kendell of Peoria. "I felt beleaguered for ISMS because of all the bills they have to track. I wish more physicians would pay attention to what's going on."

Senator Hawkinson on mandatory assignment

Kendell was pleased that her state senator, Carl Hawkinson, (R-Galesburg) joined the group for lunch. "He had to go out of his way to find us," she said. Kendell manages her husband's physical medicine, rehabilitation and rheumatology practice. "I wrote him a letter [about mandatory assignment] and explained that seniors in our practice don't want us to take assignment, because they weren't getting full value from the secondary coverage they pay for. We took assignment one year and our seniors said 'get off it,' " said Kendell. Sen. Hawkinson hand wrote his reply telling her "it is more helpful for me to understand mandatory assignment than all other correspondence combined."



ISMS auxilians gather in front of a popular Springfield restaurant frequented by legislators and political watchers while the General Assembly is in town.

Capitol experiences

Resident spouse Lynda Bartolozzi of Springfield, a respiratory therapist, said the day gave her insight into a world that she knew very little about, even though she has resided in the state capital for two years. "The average person doesn't understand the legislative process," said Bartolozzi. "I enjoyed learning how a bill gets to floor and how bills get jostled about in the committee process." Bartolozzi thanked Sen. John Davidson (R-Springfield) for voting against mandatory assignment, but barely talked with Rep. Mike Curran, who was rushing to a committee hearing.

Legislative decision making

Sylvia Eberle of Rockford found the legislative process "very disorganized." She said the auxiliary day probably had some impact and made the medical profession more visible to the legislature. "Physicians don't have time to do this themselves," she said. Eberle talked with Sen. Joyce Holmberg (D-Rockford), who voted for mandatory assignment. Holmberg said she did so because a group of seniors were there the day of the vote. Hoffmann agreed that Holmberg attributed her vote to the push of seniors.

According to Kendell, whose husband now accepts assignment on a case-by-case basis, legislators seem too ready to accept an idea that looks good on paper. She thinks they ought to look at how a proposal is going to affect the patient and the physician. "I try very hard to make our patients happy. I really enjoy our patients. We just sit down and discuss what's going on. If we're confused, so are they." Kendell's husband is a member of the American Association of Retired Persons (AARP). When he heard that AARP was supporting mandatory assignment he was outraged. "[Illinois AARP] wrote a letter to him, saying [they] did not support mandatory assignment," said Kendell. ▲

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Ob/Gyn-Family Practice-Internal Medicine—A variety of attractive opportunities for BC/BE physicians in scenic Great Lakes communities. Contact Bob Strzelczyk to discuss your practice requirements and these positions. Strelcheck & Associates, Inc.; 12724 N. Maplecrest Lane; Mequon, WI 53092; 1-800-243-4353.

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Association des Medicins de Langue Francaise (AMF) Aux Etats Unit. Joignez notre association. Tel: (312) 377-6606 (p.m.) Ecrire AMF: 6N273 Denker Road, St. Charles, Illinois 60174.

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Medical waste disposal 8

Gov. Thompson: a review of his health care record

FOLLOWING Governor James R. Thompson's July 13 announced intention to leave office in 1990, *Illinois Medicine* asked legislative colleagues and the medical community to review Thompson's record on statewide health care delivery and funding issues throughout his tenure.

Thompson's interpersonal trademarks, including persuasive talent in dealing with legislators and receptiveness to physicians' concerns will be missed, say those who know him best. "He has always listened and has always been available to listen," commented Eugene P. Johnson, M.D., president of the Illinois State Medical Society (ISMS). Organized medicine considers Thompson a "willing partner in trying to remedy problems", Dr. Johnson said, and "he will be hard to replace."

Alexander R. Lerner, ISMS executive vice president, views the governor as "a leader, a statesman and a skilled administrator. He leads by listening to all sides of an issue. His major accomplishments in the health care arena came about by taking into account the needs of patients and physicians alike." Lerner speculated on his job of forging relationships between ISMS and a new governor. "We won't fully appreciate Jim Thompson until he's no longer governor," he said.

Working for tort reform

The governor played a pivotal role with the medical community in shaping effective tort reform strategies, according to physicians involved. Alfred J. Clementi Jr., M.D. was ISMS board chairman during the 1985 successful professional liability initiative that resulted in comprehensive tort reform. He was "most impressed by the governor's ability to choose areas which would be most helpful in tort reform, formulate proper structure and then work with the House and Senate members to pass those issues into law." In Dr. Clementi's view, the 1985 tort reform campaign succeeded in large part be-

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Governor Thompson signs into law 1985 medical malpractice reforms amidst physicians and other supporters.



Jon McGinty

Demonstrators face off at the Rockford abortion clinic of Richard Ragsdale, M.D. The site has become a focal point for pro-choice and anti-abortion activists since the U.S. Supreme Court agreed to hear an Illinois abortion case involving Dr. Ragsdale's clinic.

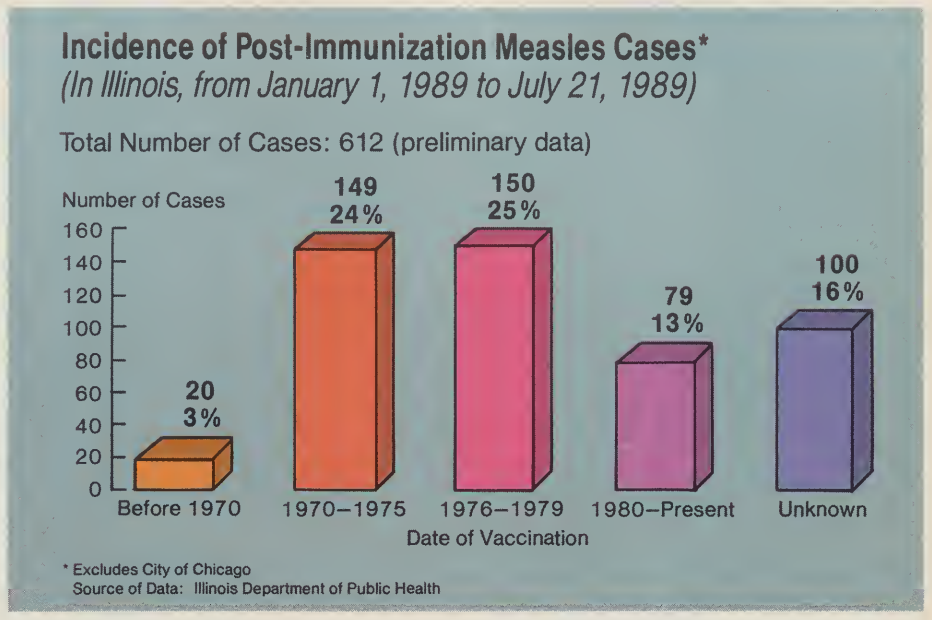
Measles outbreak signals need for vaccination increase

SINCE THE MEASLES outbreak that hit Illinois in February 1989, an average of 100 new suspected cases are being reported weekly, in Chicago, according to the Chicago Department of Health (CDH). Elsewhere in the state, the number of confirmed measles cases is declining. However the Illinois Department of Public Health (IDPH) is still investigating suspected cases.

Counties with the highest number of measles cases as of July 21 are DuPage with 153 cases, Peoria with 110, Cook, excluding Chicago, with 116 and McHenry with 72, according to IDPH. CDH confirmed Chicago has 582 measles cases as of July 24.

Two measles-related deaths have occurred in Illinois in Cook County

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Annual summer blood supply shortage recurs in Illinois

by Karen Sandrick

NORMALLY, ILLINOIS blood banks and blood services maintain a large enough supply of blood to meet demands. In the summer months, however, supplies barely meet demands and at times run short. LifeSource, a Glenview-based blood supplier, usually provides 600 units daily to area hospitals. As of July 19, that figure was down 15 percent, according to Elizabeth Hall, a marketing associate. She noted that summer vacations for high school and college students, who are donor sources, are probably to blame for the decline. LifeSource also "lost 1,000 units this summer" due to cancellation of annual employee blood drives at Sears and Carson Pirie Scott.

The Chicago blood supply is "approaching critical levels for O negative and B positive blood types," she said. If and when the shortage becomes more acute, LifeSource plans to contact hospitals and request postponement of elective surgical procedures, Hall added.

The American Red Cross in Peoria reports no current shortage, but they have "a tight supply," due to increased trauma and need for transfusions this summer, according to Tom Hoffman, director of the laboratory. He said that despite current difficulty collecting blood at Caterpillar Company, an important donor source, the Red Cross is still able to meet the area's need for 350-400 units daily.

The shortages are due more to people's lifestyle changes than anything else. Although donations initially dropped off in 1985 because of concern about acquired immune deficiency syndrome (AIDS), the number of blood donors in downstate McLean County has steadily risen in recent years, and blood donations are holding firm in the Chicago area as well.



Charles Ross of the Signode Corp. donates blood. Historically, summer is a time for blood supply shortages. (Photo courtesy of LifeSource.)

Constant vigilance and effort needed

Maintaining an adequate and safe state blood supply does, however, require constant vigilance and continued efforts to ensure proper utilization of this scarce medical resource, experts say.

Historically, summertime has been a period of blood supply shortages. The McLean County chapter of the American Red Cross tries to have a three-day supply of blood on the shelves but sometimes finds only one or two day's worth of blood because of the increased need for transfusions.

"In the summer, people are active, or they're vacationing in their cars, and there are accidents," says Jan Kancius, director of the chapter.

And multiple major traumas can quickly deplete the supply of a particular blood type. Not long ago, Kancius recalls, four major traumas in the region over one early summer weekend used up the chapter's units

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Measles

(continued from page 1)

and Chicago during the last several weeks.

Chicago and DuPage

Edward F. Mihalek, director of Chicago's immunization program said the city's preschoolers have been most affected. "We're finding that over 80 percent of the children who have come down with measles are eligible for the measles vaccination, but haven't been immunized."

Hispanics and blacks ranging from age 16 months to four years account for the majority of measles cases in the Chicago area. Individuals between the ages of 15 and 19 accounted for most of the downstate measles cases.

Last May, CDH recommended private physicians review patient records and immunize infants with a combined measles, mumps and rubella (MMR) vaccine at 12 months of age. The department has lowered the recommended age for first time immunization to six months in Chicago health department clinics.

Gary Gardner, M.D., a pediatrician in DuPage County and president of the Illinois chapter of the American Academy of Pediatrics (AAP) said, "What has alarmed pediatricians is that the outbreak hit middle school children aged 10 to 15 the hardest in DuPage County. In fact, most of these cases occurred in kids who had received the measles vaccine so there's some concern about the long term efficacy."

"Pediatricians regard this as a serious epidemic. It's got everyone very concerned," Dr. Gardner added.

State and national recommendations

The nation has had a 300 percent increase in measles from last year according to the Centers for Disease Control (CDC). AAP revised its measles vaccination policy "to increase immunization in unvaccinated preschool-age children in high risk areas, and to prevent the spread of measles in schools and colleges by giving all children routine second doses later in life."

AAP recommends all children be given two doses of the MMR vaccine, at 15 months of age and again before beginning middle or junior high school. AAP notes physicians who choose to revaccinate children at an earlier age, such as five year-olds, don't have to give a third dose when children begin middle school, as long as the first two doses are after age one and the vaccinations are separated by at least three months.

In high-risk areas, AAP recommends pre-school age children be vaccinated at 12 months of age. Children vaccinated before the age of one year should be revaccinated with MMR at 15 months and given a third dose before starting junior high.

In cases of school outbreaks, AAP recommends that children and their siblings be revaccinated if they were born after January 1, 1957.

IDPH recommends individuals in high-risk areas receive immunization at 15 months. If vaccination occurred prior to 1980 and 15 months of age, a second dose should be given after 15 months. IDPH plans to amend its administrative rules to reflect the national measles vaccination recommendations.

Universities get tough

Bradley University officials in Peoria said there have been no new measles cases on campus, where the state's first case was reported in mid-February this year. The Peoria student is believed to have contracted it in the St. Louis area, according to Henry Gross, M.D., Bradley University health center medical director and chairman of the department of family practice at St. Francis Hospital. More than 100 confirmed and suspected measles cases occurred at Bradley during the outbreak.

Bradley will be enforcing stricter immunization requirements this fall because of the recent outbreak. "Unfortunately, we haven't had any teeth to enforce the vaccination requirement, but a new administrative policy taking effect this fall will prevent any student from registering if his or her immunization form isn't turned in," said Dr. Gross.

Emphasis on physicians' role

Dr. Gross also questioned the durability of the measles vaccine. "What we saw at Bradley clearly was that the vaccine did not last from age 15 months to age 18 years. A number of students who contracted measles had been vaccinated at 15 months." He added, "all universities and physicians should reexamine immunization procedures to try and bring all patients up to date, not only children, but adults as well."

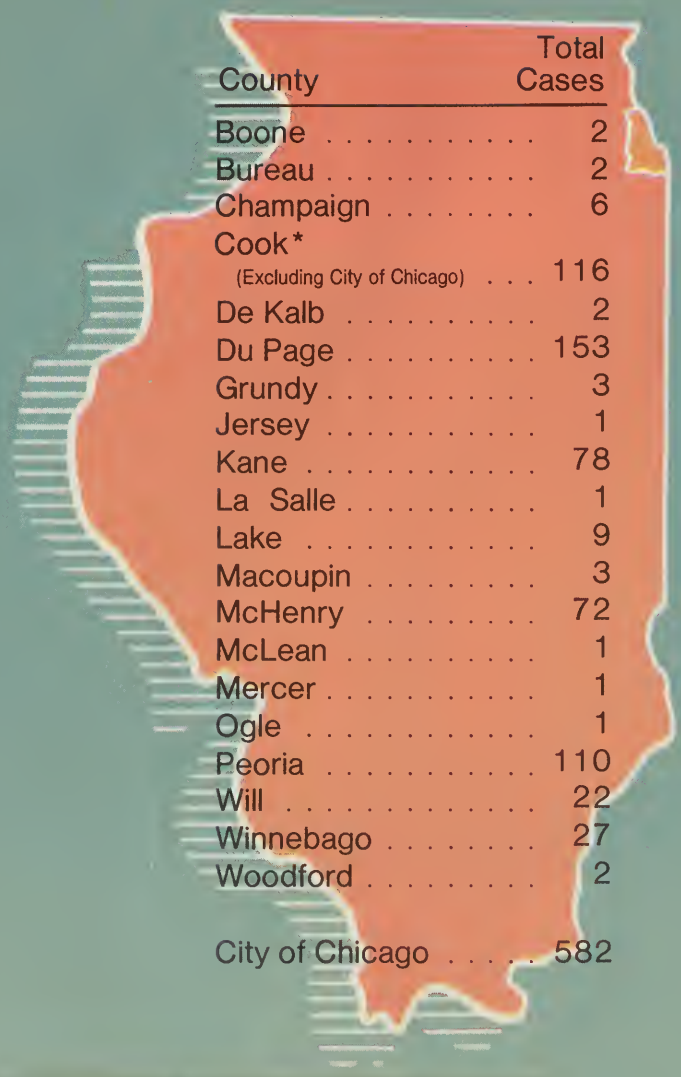
"The reporting of measles cases will help us determine what is happening in the outbreak locations. We need this information to identify

(continued on page 3)

Physician Facts

Measles Cases in Illinois by County

1989 Total: 1194*
1988 Total: 72



County	Total Cases
Boone	2
Bureau	2
Champaign	6
Cook* (Excluding City of Chicago)	116
De Kalb	2
Du Page	153
Grundy	3
Jersey	1
Kane	78
La Salle	1
Lake	9
Macoupin	3
McHenry	72
McLean	1
Mercer	1
Ogle	1
Peoria	110
Will	22
Winnebago	27
Woodford	2
City of Chicago	582

* From January 1, 1989 to July 21, 1989; City of Chicago, from January 1, 1989 to July 24, 1989

Source of Data: Illinois Department of Public Health and the City of Chicago Department of Health

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Gov. signs public aid appropriations

INCREASING ACCESS to medical care for low-income patients will result from the Illinois Department of Public Aid's (IDPA) fiscal year 1990 appropriations bill, according to Governor James R. Thompson, who signed the bill July 17.

"The state's Medicaid program will only work if there are participating physicians involved" said the Governor. "One way to ensure physicians will participate is to ensure they are paid adequately for their services. That's why increasing physician rates was needed to improve access to care for those with low incomes."

Along with cost of living, and heating and electricity increases, Illinois' poor will benefit from increases for physician and hospital care, beginning September 1, 1989. The physician budgetary allocation rises from $163 million in fiscal year 1989 to $192 million in fiscal year 1990, which began July 1, 1989.

The additional funds, made possible in part from the tax increase passed by the Illinois General Assembly, increase routine office visit reimbursement 42.3 percent or, up to $18 from $12.65. The July 21, 1989 issue of *Illinois Medicine* reported preliminary estimates for the increase as 40 percent. Department spokesmen have now confirmed the higher 42.3 percent increase figure as final.

"This is the biggest single step in IDPA fees," said Eugene P. Johnson, M.D., Illinois State Medical Society president. "The department's fee schedule has, over the years, severely deteriorated and caused access problems for patients. These raises won't make public aid competitive with private payors. But it demonstrates significant, meaningful progress."

"We're much closer than we've ever been before in keeping up with inflation and physicians' expenses."

Physicians can expect to be reimbursed nearly $800 for comprehensive OB care provided to Medicaid recipients after September 1, instead of the current $446. "OB reimbursement was far behind most. Now that this reimbursement is dramatically raised statewide for comprehensive OB care, the result should be better access to prenatal care," said Dr. Johnson.

In addition to the increase in office visits, statewide comprehensive obstetrical and "Healthy Kids" reimbursement, surgi-pak reimbursement will be increased 20 percent, and all services not otherwise affected will be increased 16.5 percent across the board. Previously reported in *Illinois Medicine* as 12 percent, this figure has also been finalized at a higher increase by IDPA.

Alfred J. Kiessel, M.D., chairman of the Society's third party payment processes (TPPP) committee, echoed Dr. Johnson's comments. "The Governor, the General Assembly and ISMS have demonstrated their concern for public aid patients and the physicians who care for them with this important step. It is frustrating to deal with bureaucracies of any type. But by carefully building legislative and executive branch support for these raises, I believe we have made a real difference here."

Dr. Johnson further observed, "There are still many problems left to be addressed in public aid. However, it is clear that substantial progress has been made. I strongly encourage physicians to continue to serve the health needs of IDPA patients and to insure that access to desperately-needed care is guaranteed."

Governor Thompson expressed hope that doctors will recognize the need for treating public aid patients and will now join the program. "The need for physicians to care for the poor is great," he said, "and these increases should go a long way toward improving access to care for those less fortunate."

"Our goal," said IDPA director Susan Suter, "is to increase access to medical care for the needy in Illinois, and to get children the medical care they need, especially preventive medical care."

IDPA will be providing further details of the increases to physicians and other providers. ▲

Measles

(continued from page 2)

people who've been exposed so we can work with them or their physicians," said Ralph Cordell, Ph.D., director of the communicable disease division at the Cook County Department of Public Health (CCDPH).

A big barrier in stopping the spread of measles is the immigration of youngsters who have never been immunized said Lawrence Elegant, M.D., a specialist in pediatric allergies. "Chicago has its share of the population who come from areas where preventive medicine is not really practiced as well as it should be." He added, "Education is the most important to keep in mind. We as physicians have to reach out and not wait for people to come in for immunizations or the measles outbreak will recur."

Karen Scott, M.D., director of CCDPH said physicians should be especially aware that patients have difficulty keeping track of immunization records. "A 15-year-old child who comes down with measles may have moved three or four times. Sometimes people just don't keep their records and are confused about what immunizations they've had." ▲

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

ICD-9 CODING

Based on the Medicare Catastrophic Act of 1988, physicians are required to submit ICD-9 diagnosis codes on claims submitted for services rendered on and after April 1, 1989.

This includes both assigned and non-assigned claims billed on the HCFA-1500 via paper or electronic media and itemized bills submitted by the beneficiary with the HCFA-1490s.

Use of diagnosis coding is being monitored and educational contacts will be made or development letters will be sent to physicians who fail to use ICD-9 codes.

Physicians should report a minimum of one ICD-9 code per claim. However, there may be instances where the patient has more than one condition causing his/her encounter with the physician. Claim limitations allow the reporting of only four diagnosis codes. The physician should first select the ICD-9 code that represents the main reason for the encounter. In selecting the other three conditions to report, the physician should attempt to select those conditions for which procedure codes are listed and to which the procedures were directed.

Codes are to be used at their highest level of specificity, and as accurately as possible describe the condition being treated. For example, a 3-digit ICD-9 code should be used *only* if there are no 4-digit codes within that code category.

ICD-9 codes should be placed in box 23 of the HCFA 1500 claim form. *In addition,* the ICD-9 code or reference number from line 1, 2, 3 or 4 of box 23 should be placed in column 24d to relate the appropriate diagnosis to the dates of service and the procedure performed.

Physicians who bill *electronically* will be sent special instructions regarding the submission fo this information on electronic claims.

Physicians who do not accept assignment and instead bill a patient directly by statement or superbill *must* clearly indicate ICD-9 codes on the patient's bill.

Additional guidelines to following when selecting an ICD-9 code:

- — Chronic diseases that are treated on an ongoing basis may be coded and reported as many times as the patient is receiving treatment and care for that condition.
- — "Rule out", "probable", "suspected" diagnosis codes should not be reported. Instead code to the highest degree of certainty for the encounter/visit. ICD-9 codes for the patient's symptoms and signs are appropriate.
- — Pathologists and radiologists should use the appropriate "V" code as the reason for the encounter if the patient is receiving only therapeutic or diagnostic services. The "V" code should be followed by the ICD-9 code(s) for the sign, symptom or diagnosis that necessitated the therapy, x-ray or laboratory procedure.

INJECTABLE DRUG — LUPRON DEPOT — NOW COVERED

Lupron Depot, an injectable drug for the treatment of prostate cancer, has recently been approved by the Food and Drug administration effective with dates of service on or after January 26, 1989.

Use the procedure code **J9999** which is "not otherwise classified" code, when billing for this drug. State the complete name of the drug and dosage (up to 1.5 ml). Include the appropriate modifier to indicate the method of administration — WV (intravenous) *or* WM (intramuscular).

EMC NOTE: Do not bill this procedure code electronically. Instead, submit on a paper claim.

PSYCHIATRIC BENEFITS — BRIEF OFFICE VISIT

Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, and personality disorders are *NOT* subject to the annual psychiatric benefit limitation.

A new HCPCS procedure code has been developed, for services provided January 1, 1989 and after:

Q0044 Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic and personality disorders.

Correct use of this code will permit correct payment. The psychiatric limitation *will* apply if the above service is *incorrectly* coded as 90040.

(This report is a service to the physicians of Illinois)
8/4/89

Editorials

Governor Jim Thompson: Standing tall for quality health care

As Illinois ponders the prospect of life without Jim Thompson in the governor's chair, it's already apparent he's going to be a "tough act to follow" in terms of improving and expanding health care services across the state. As noted in this *Illinois Medicine,* he recognized the problems besetting patients and providers alike, and he scored major accomplishments that have long-range positive impact for everyone.

Among his most significant credits is an immeasurably improved malpractice climate. Thompson established himself as one of the most progressive public officials in the nation by effectively leading the way to successful 1985 tort reforms. That achievement correctly worked toward restoring fairness in the courtroom for patients and physicians, and put Illinois on a better track to solving malpractice litigation problems.

Governor Thompson also deserves plaudits for his courageous stances. Among them, he called for a tax increase to improve funding for the state's troubled public aid program. He also applied energetic leadership on wide-ranging health care issues, including many public health advancements he advocated and achieved. He will be missed.

Blood donation: Still the best gift

The seasonal slowdown in blood donations points out the need for community blood centers and hospitals to step up recruitment efforts for healthy blood donors throughout the year, to avoid periodic tight supplies.

Vacation time reduces the number of donors at mobile blood drawings, and the public does not often give the continuing need for donation much thought. There's another important factor underlying the episodic shortages: too many potential donors are still needlessly scared off by a groundless fear of acquiring AIDS through blood donation. To help destroy that myth, physicians should correctly inform patients, as well as their relatives and friends, that blood donation is safe. We must highlight the importance and safety of the donation process as well as the sophisticated post-donation screening methods used to assure safety at all blood centers. The use of designated donors is not risk-free, and the need for people to donate on behalf of the general community is still important, since many people who need blood do not have friends or relatives willing or able to be donors.

Blood is a unifying, critical resource for every human being, and it remains a most meaningful gift to give or receive. ▲

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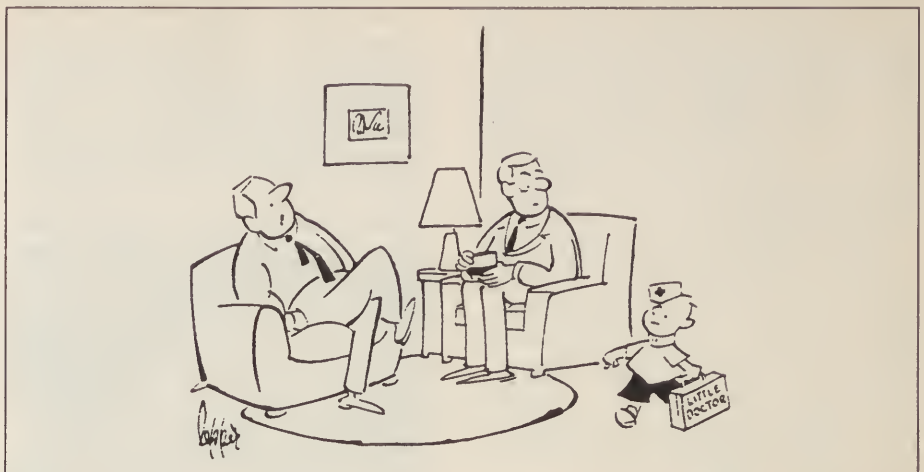
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Guest Editorial

Task force takes on tobacco industry

by Rep. Richard J. Durbin



THE TOBACCO industry has long had a reputation as one of the most powerful lobby groups in Washington. In fact, tobacco is so ingrained in America's past that it's literally a fixture in our national legislature.

For instance, those decorative wooden leaves carved into the speaker's rostrum in the U.S. House of Representatives aren't sprigs of laurel; they're tobacco. Tobacco was one of the earliest exports America sent back to the Old World, and the cash generated by tobacco helped finance our war of independence. It remains a major economic force to this day.

Notwithstanding the symbols of tobacco's power, about three dozen members of Congress have taken a step that is more than symbolic: We formed the Congressional Task Force on Tobacco and Health. For the first time, a formal alliance has been established in Congress to address the legacy of death and disease that tobacco also has left our country.

Given the political and financial resources of the tobacco conglomerates and their most visible lobby group in Washington, the Tobacco Institute, our task force is not likely to win us a lot of dinner invitations or campaign contributions.

Consider just one of the tobacco giants, Philip Morris. Federal Election Commission records show its political action committee raised its campaign contributions to congressional candidates from $9,400 in 1977-78 to $276,306 in 1987-88, an increase of 3,000 percent. The total number of tobacco-industry PACs virtually tripled, and the total amount contributed by those PACs rose from $94,200 to $644,415—an increase of 584 percent. And that doesn't even touch political activity by such secondary tobacco-related forces as the billboard and vending-machine industries.

By comparison, the health lobby in Washington is smaller, much more diverse and less well-heeled. Three of the most active health groups—the American Cancer Society, the American Lung Association and the American Heart Association—are nonprofit and prohibited from making any political contributions.

Our task force, unlike most other legislative focus groups, has no membership fees, no independent staff, no separate office and no money. Nonetheless, it does represent an unprecedented and historic political step for the public health movement in Congress. For the first time, there is a central clearinghouse to help educate other lawmakers about tobacco use and its health effects. For the first time, there is a formal alliance designed to build coalitions with other congressional organizations and public groups, and to develop strategies for advancing tobacco-related health legislation. As the tobacco industry knows so well, you need allies if you hope to win on Capitol Hill.

Each year, 390,000 Americans die from diseases caused by tobacco use. Each year, smoking costs the American economy $65 billion in health care and lost productivity, including nearly $5 billion in medical costs paid by the taxpayers. To echo ex-Surgeon General C. Everett Koop, smoking is the single largest preventable cause of death in the United States—more so than illegal drugs, AIDS or assault rifles.

For those of us who believe that government has a fundamental responsibility to preserve and protect the public health, smoking is a public health issue that simply cannot be ignored. The tobacco industry argues that smoking is a matter of personal choice, and so it is; but when does a personal habit take priority over the health and safety of others? As a matter of basic fairness and long-established public policy, personal choice does not allow someone to put others at risk. ▲

U.S. Representative Richard J. Durbin (D-Springfield) is co-chairman of the Congressional Task Force on Tobacco and Health.

The abortion debate: Give us your opinion

ABORTION is among the most controversial topics in Illinois today, and we're interested in how you, our readers, view the issue.

Illinois Medicine invites your comment on the following question: **Should the state restrict abortion, and if so, to what extent?**

Commentary should be limited to 250 words or less, typed or printed clearly, and sent to *Illinois Medicine*, Suite 700, Twenty North Michigan Avenue, Chicago, IL 60602.

August 15 is the deadline for submission of commentary to appear in an upcoming *Illinois Medicine* "Open Forum" on abortion. All letters are subject to editing. ▲

Back tax deadline of August 15 approaching

PHYSICIANS WHO believe they owe back service occupation taxes have until **August 15** to file a return and then pay the tax in order to be considered for the Department of Revenue's program for waiving of interest and penalties. Follow this step-by-step procedure to determine your liability. However, physicians are advised to consult with their own tax advisors throughout this process.

- Check past invoices to determine whether materials or merchandise has been bought from any out-of-state suppliers.
- Determine whether the out-of-state supplier is registered with the Department of Revenue for service occupation tax purposes. The most reliable method for doing this is to contact your suppliers and ask if they are registered in Illinois. National suppliers will in most instances be registered and charging tax. If they are not registered, then service occupation tax has not been paid.
- If you determine that no service occupation tax has been paid on your out-of-state purchases, you are probably subject to tax. You should now call the Department of Revenue at their toll-free number **1-800-732-8866** and request the Step-By-Step For Voluntary Compliance By Medical Professionals packet of information. The packet includes step-by-step instructions for computing your tax, appropriate tax returns, and a form for filing an appeal with the Board of Appeals to have interest and penalties waived. ▲

New Medicare forms required for home oxygen therapy

BLUE CROSS/Blue Shield has advised *Illinois Medicine* that as of August 1, 1989, the Health Care Financing Administration (HCFA) requires physicians to use new forms to certify medical necessity for home oxygen therapy.

The new HCFA-484 form will standardize information Medicare uses to evaluate whether payment for home oxygen therapy can be made. HCFA-484 is the *only* acceptable form for home oxygen services, and must be used for any initial, revised or renewed certifications completed on or after August 1.

Only the physician or office assistant employed by the physician may complete the HCFA-484, to meet the physician's responsibility for the accuracy of the information. Physicians should use standard Medicare ICD-9 codes to describe the patient's condition, in providing medical necessity evidence for use of home oxygen.

HCFA has generated this form without input from the Illinois State Medical Society (ISMS) and the American Medical Association (AMA). ISMS will raise any member concerns with HCFA and the AMA.

HCFA-484 forms may be obtained by calling (618) 997-3190 or by writing Blue Cross/Blue Shield of Illinois, Medicare B - Freedom of Information, P.O. Box 992, Marion, Illinois 62959. ▲

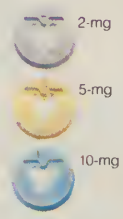


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Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If this were your patient, how would you have handled this case?

Presenting case and initial diagnosis—A 36-year-old construction worker was brought to a hospital emergency room with a cut over his right eye suffered in a brawl and subsequent fall in a nearby tavern. The immediate examination showed no neurological deficit but that the patient was intoxicated.

The case in brief—When he arrived in the emergency room, the patient was combative, uncooperative and resisted treatment. The emergency room physician and other staff attempted to quiet the patient unsuccessfully. He was restrained temporarily while the physician examined him and treated the cut on his forehead. The emergency room physician noted visual signs of intoxication and drew a blood sample to determine the blood alcohol content (BAC). When the test results returned, the BAC was found to be .028.

The patient was retained in the emergency room for five hours until a friend arrived to take him home. No skull x-rays were taken. By morning the patient had begun to notice left-sided facial weakness and he had a severe headache. He vomited and appeared somewhat disoriented. At this point, his friend brought him back to the ER.

A second examination revealed that neurological deficit had occurred. An EEG and brain scan were ordered and a diagnosis of concussion was made. Librium was administered and he was admitted to the hospital. Over the next four days his condition deteriorated. Another CT scan was ordered which revealed a large right intracerebral hematoma in the posterotemporal area. A craniotomy was performed immediately. However, although the patient recovered, he had moderately severe bilateral cerebral dysfunction, focal epileptic form changes, and right foot drop.

The resulting claim—The patient sued for negligent failure to diagnose a subdural hematoma and delay in treatment contributing to his continuing disabilities.

The outcome of the claim—The case was settled by the hospital and by the emergency room physician for $150,000.

The points this case makes—Consultants were critical of the emergency room physician's failure to obtain a skull x-ray, even though initial evaluation gave no indication of neurological deficit. This case typefies those in which intoxication impedes proper diagnosis and treatment.

Intoxication is one of the most difficult problems that an emergency room and its personnel must handle. The incidence of intoxicated patients is very high. A study at Denver General Hospital during a one-month period revealed that 80 percent of emergency patients presenting in the emergency room had some direct or indirect connection to alcohol abuse, according to a report by Peter J. Rosen, M.D. and John A. Marx, M.D.

Intoxicated patients sometimes are hostile, abusive and almost always difficult to manage. They can also present a physical threat to emergency room staff. Because they are combative and uncooperative, it is often very difficult to perform a thorough, accurate evaluation of their possible problems.

Furthermore, intoxication can mask injuries. "For example, almost all of the findings of head injury can be hidden by alcoholic intoxication, and many of the symptoms that would ordinarily produce any extensive and aggressive neurosurgical evaluation of the patient are wrongly ascribed to alcohol. Metabolic disturbances such as hypoglycemia or seizure create similar misinterpretations," wrote Drs. Rosen and Marx.

The physicians said the following steps would avoid problems that can arise in diagnosing and treating the intoxicated patient:

- —Fully evaluate the patient even though alcohol is in the system. Obtain a blood alcohol test either by breathalyzer or blood sample to determine the level of blood alcohol.
- —Be cognizant of the fact that you may be dealing with a chronic alcoholic with surrounding associated pathologies.
- —Administer multivitamins, thiamine and glucose intravenously especially if the patient is a chronic abuser.
- —Position the patient to guard against aspiration if he or she vomits.
- —If the patient is unconscious or falls asleep, periodically arouse him/her so that any abnormal mental status or focal findings can be detected early.
- —Do not discharge the patient until a pre-discharge evaluation has been made. Sometimes a patient

(continued on page 7)



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Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *Do I need to have admitting privileges at a hospital in order to obtain an insurance policy with the Exchange?*

A: All applicants and existing insureds must have admitting privileges at at least one hospital. The only exceptions to this rule are hospital based radiologists, pathologists, and emergency medicine specialists. Physicians practicing any other specialties should contact the underwriting department for further information.

Q: *Our group is adding another physician to our staff. Does he need to be insured with the Exchange, or can he be insured with a separate carrier?*

A: The Exchange requires that all physicians in a group be insured with the Exchange, and carry equal or higher limits of liability. In the event of a claim or suit, it is beneficial to the Exchange and the insured group to have only one insurer involved. This prevents potential coverage disputes between insurers that could complicate resolution of a claim.

Q: *What is a declarations (DEC) page and when is it issued?*

A: The declarations page is a policy document outlining the specific terms and conditions of the individual insurance policy. It is issued at the beginning of your policy and every year thereafter on July 1, after receipt of the quarter's premium payment. This is an important document that should be promptly filed with your policy. Occasionally, amended declarations may also be issued. Declaration pages are not invoices. Billing is issued separately. ▲

Q: *If illness makes me unable to practice medicine for a few months, what effect will this have on my policy?*

A: Suspended coverage is available to physicians who will be absent from medical practice for at least one month, for a maximum of twelve months, due to incapacitating illness or disability. Suspended coverage allows the physician's policy to be placed on inactive status at a reduced premium. However, the physician has no coverage for direct patient contact while the policy is suspended and a letter from the treating physician attesting to the physician's ability to resume the practice of medicine is required in order to reactivate the policy.

Q: *Why does my membership with the county medical society affect my insurance policy?*

A: To be an ISMIE policyholder a physician must be a member of the Illinois State Medical Society (ISMS). ISMS requires unified membership in the county and the American Medical Association (AMA), along with the state society membership. Unified membership has made organized medicine strong in Illinois. We have one of the strongest AMA delegations and our position on many issues prevails at the national level. Physicians continue to face serious issues at all levels of government which affect medical practice and health care delivery. Only through a unified voice can physicians speak on issues before the government at all of these levels.

The Illinois State Medical Inter-Insurance Exchange was founded by ISMS at a time when commercial insurers were abandoning the Illinos physician. Eligibility for ISMIE insurance is just one of the many membership benefits of organized medicine in Illinois. ▲

Case in Point

(continued from page 6)

does not voice any complaints or exhibit abnormal behavior until sober.

—Observe the lethargic patient until the alcohol has been metabolized. "If the patient's return toward normal is not as quick as one would predict, this may be the first clue to an intracranial lesion," Drs. Rosen and Marx said.

—Restrain the patient as necessary not only for examination and treatment, but to prevent the patient from injuring himself/herself or ER staff.

—Do not permit the patient to leave the emergency room until he or she can walk, talk and care for himself/herself.

An encounter with a hospital emergency room may be the event that can lead an alcohol abuser to face up to problems and take the first steps toward dealing with them. It can also be the trigger for a costly malpractice suit if ER staff allows the presence of alcohol to interfere with sound diagnosis and treatment. ▲

Source: *SVMIC News,* "Alcohol and the Emergency Department," by Peter J. Rosen, M.D. and John A. Marx, M.D. May-June, 1987.

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Getting rid of medical waste will be big problem for MDs

by Tina Panoplos

TAKING OUT the trash is becoming increasingly more complicated for physicians as federal legislation and local ordinances begin to place greater restrictions on how and where they can dispose of certain types of medical waste.

In DuPage County, health care professionals are facing a "not-in-my-backyard" attitude towards disposal of their medical wastes.

Last fall, the DuPage County Forest Preserve District passed an ordinance prohibiting the disposal of what it termed "hazardous (infectious) medical waste" in its landfills. The categories of waste covered were all sharps and pathological wastes, plus a long list of additional wastes including all materials discarded from surgical procedures, solid and liquid wastes from renal dialysis, chemotherapy waste, animal carcasses exposed to pathogens in research, serums and vaccines not returned to the manufacturer at point of origin, wastes from the care or treatment of patients in isolation and biological wastes defined as "excretions, exudates, secretions, suctionings and other body fluids that cannot be directly discarded into a municipal sewer system."



Richard Utt, superintendent of government services for the Forest Preserve District of DuPage County, said that the landfill would accept wastes rendered innocuous through autoclaving, but would not accept sharps. The ordinance not only covers hospitals, but also physicians' offices and veterinary and dental clinics.

Utt claimed that the county has received a "good response" to its medical waste ordinance. Representatives from two of the country's largest waste disposal companies—Waste Management, Inc., and Browning-Ferris Industries—have been available to answer health professionals' questions about the "most efficient and economical way" to properly contain and dispose of their medical wastes, according to Utt.

Morgan Meyer, M.D., of Lombard, is among those critical of the ordinance.

"It's using a buffalo gun for a mosquito," Dr. Meyer said. He criticized the ordinance for covering virtually every rectal glove to every band-aid that has blood on it.

"They're going overboard so they can say [the landfill] is safe," he said.

Raymond Dieter Jr., M.D., another DuPage County physician, introduced a resolution at the Illinois State Medical Society's (ISMS) April House of Delegates meeting calling for the society to introduce and support legislation that would explicitly define hazardous medical waste and establish guidelines for its proper disposal.

While Dr. Meyer acknowledged that introducing legislation could lead to broader and more stringent definitions of hazardous waste in the state, he added that, "At least we'd have some way of having input."

Dr. Dieter said he introduced the legislation to stir up debate on the topic.

"I'm not interested in a flap with local representatives," he said. "I'm interested in working with them."

Utt said the ordinance was introduced because they were finding "a substantial number" of needles and other sharps at the landfill that "should have been incinerated."

With the landfill refusing to accept sharps and the lack of incineration facilities in DuPage County, physicians are being forced to contract with special waste haulers to ship their sharps out of the county.

What's going on in DuPage County mirrors what's happening on a state and national level.

Federal and state moves

Last October, Congress passed a measure that set up a two-year demonstration program for tracking medical waste in 10 states. The act was prompted by the syringes and other medical waste that washed up on beaches on the East Coast and parts of the Great Lakes last summer.

The federal Medical Waste Tracking Act of 1988, which originally covered 11 categories of medical waste, was pared down by the U.S. EPA to include five categories: cultures and stocks of infectious agents; pathological wastes; blood and blood products; sharps; and animal carcasses that were exposed to infectious agents in research. New York, New Jersey and Connecticut are required to participate in the program, while the seven states bordering the Great Lakes were allowed to opt out of the program.

In April, Gov. James R. Thompson announced that Illinois was opting out of the program, instead setting up a study group to look at state laws governing medical waste disposal.

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Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE ANO ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE ANO ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonsirated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross lhe placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSO) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 palients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhylhm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE ANO ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diurefics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Oosage should be adjusted according to blood pressure response. The usual dosage range is 10 lo 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypolension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See OOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486.

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"The problems associated with the improper disposal will not be solved, nor are in some cases even addressed, by the tracking rules which the U.S. EPA has established, and the program would be too costly for the state to undertake at this time," Thompson said in a statement.

The medical waste tracking group

Bernard Killian, director of the Illinois EPA, and Bernard Turnock, M.D., director of the Department of Public Health, will head the Medical Waste Tracking Study Group. The group will include representatives of the General Assembly, the medical and health care community, waste management organizations, consumer groups and state agencies.

In a letter dated April 21 to William K. Reilly, U.S. EPA administrator, Thompson indicated that hospitals in Illinois, which would account for 60 percent of the waste in Illinois outlined in the federal program, are already tracking "infectious" medical wastes. He added that, according to medical waste generators in Illinois, these wastes pose little threat to the public health. In addition, he said, the federal waste tracking program would cost Illinois about $700,000, while federal funding for the program for all participating states plus the U.S. EPA has been proposed at just $500,000.

Illinois' current tracking program for hospitals covers about 250 generators of medical waste, according to Ann Guild, director of medical staff affairs for the Illinois Hospital Association.

The federal tracking program, on the other hand, would affect any generator of 50 pounds or more of covered medical wastes a month. In Illinois, that includes more than 50,000 generators, according to Rob Watson, environmental protection engineer for the Illinois EPA.

While Illinois has opted out of the federal program, the medical waste ordinance in DuPage County serves as a reminder that health care professionals in Illinois might yet face more stringent regulations on the disposal of medical wastes.

How much these regulations will cost physicians will depend on where they live and how much and what type of waste they generate.

What MD's can expect

Janet Emmerman, director of medical services at Waste Management, Inc., said that physicians could pay an average of up to $40 a month to have their sharps and other such wastes hauled. Mark Sheppard, plant engineer for National Environmental Services, Inc., estimated the cost at $1 per pound of waste, less for large generators of waste.

Waste Management just started handling medical waste about two years ago. NES opened its operations in Clinton on March 17. The company services medical waste generators within a 75-mile radius of Clinton.

Both companies incinerate the medical wastes they haul. Sheppard, who said his company handles 29,000 to 30,000 pounds of medical waste in every 24-hour period, said incineration allows them to reduce this waste by 97 percent.

Emmerman of Waste Management said they feel that incineration is the most complete method of disposing of medical wastes in terms of reducing its volume and rendering it safe.

Watson noted that incineration is the most tested and probably most common of the technologies available for disposing of medical wastes. As to whether it's safer than landfilling, he pointed out that biological agents need enough food, the right temperature, and the right moisture content.

"Biological agents aren't going to survive in a landfill environment," he said.

Kay O'Connor, infection control coordinator at Holy Family Hospital in Des Plaines, said studies have shown that hospital waste isn't any more infectious than residential waste. While she said that precautions should be taken with certain

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Contracting with waste haulers

Before you sign a contract to have medical waste hauled by a disposal company, make sure you've done your homework. Rob Watson of the Illinois EPA and Sharon Muraoka of the Metropolitan Chicago Healthcare Council offered these suggestions.

- Be aware of the regulations regarding the disposal of medical waste in your area, including Illinois and federal EPA regulations, Illinois Department of Health guidelines and county and local ordinances.
- Ask potential haulers how they will assure effective disposal of your medical waste.
- Ask what other customers are using the waste hauler. Call some of the customers to find out if they've been pleased with the service or if they've had any problems.
- Know exactly where the hauler is taking the waste and obtain hard copies of permits for the receiving site.
- Call state agencies that regulate the site and make sure it is in compliance with state and local ordinances.
- Visit the disposal site. Watson said "sloppy housekeeping" on the part of the site could put you at risk for future liability. ▲

When a second opinion is needed . . .

To ease the referral process . . .

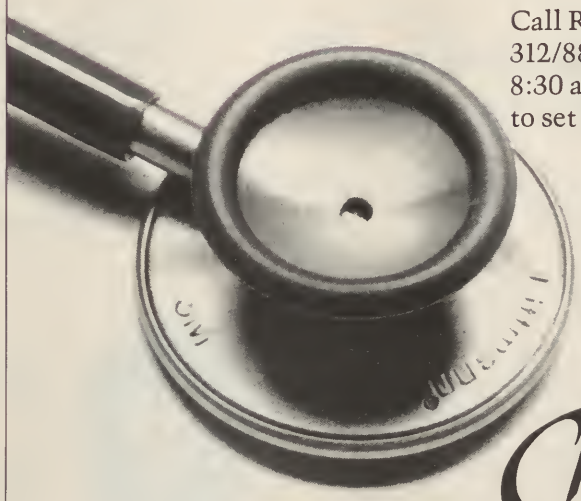


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An "open door to medicine," says dad

James R. Thompson, M.D., a pathologist, long-time active ISMS member and the governor's father, learned early of his offspring's determination and leadership goals. "In seventh grade he said he wanted to be president of the United States by 1984," Dr. Thompson recalled. "He was always interested in politics," he said.

In 1954, during Dr. Thompson's army duty in St. Louis, young Jim Thompson asked his father to accompany him to hear a political campaign talk given by Adlai Stevenson, the Democratic presidential hopeful. According to Dr. Thompson, his son got permission from Stevenson's manager to meet Stevenson and have his picture taken with him. They posed together, and Stevenson autographed the photograph. The candidate later sent young Jim Thompson a letter, thanking him for his interest, "saying he wished more young people would get involved in politics." Thompson later twice defeated the candidate's son, Adlai Stevenson III, in Illinois gubernatorial contests.

In his father's view, the governor "wisely worked closely with the medical society, and all the officers were very pleased that he had an open door. He was very understanding of our problems." ▲

Governor Thompson

(continued from page 1)

cause "of Thompson's stubbornness to push forward his commitment to it." House Republican leader Rep. Lee Daniels agrees, saying the governor "consistently took the position we needed to [achieve] reform."

Philip Corboy, partner in Corboy and Demetrio, a Chicago law firm specializing in plaintiffs' medical malpractice cases, doesn't question the governor's overall record—"he was a very good governor and he's a very nice guy". But, in Corboy's opinion, Governor Thompson made "errors of judgment" in supporting tort reform, by "accepting the propaganda spread by the [physicians'] insurance companies, to the detriment of the consumer public and his constituency." The governor "got taken in by the nonsense insurance companies talked about."

Corboy was especially critical of the section of the 1985 tort reform or "tort destruction" statute which was "pushed down the throats of the public" and "which prohibited people from suing a physician for punitive damages. We're the only state in the country to insulate physicians against penalty." Attorneys are also protected under the legislation, and "the governor signed it," noted Corboy.

Joseph Skom, M.D., a member of the American Medical Association (AMA) Council on Scientific Affairs, was ISMS president in 1976-77, and remembers the governor's early support of malpractice reform. "At the time, the trial lawyers' association had such a powerful lobby, we got nowhere. Doctors were leaving practice

(continued on page 11)

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage, although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

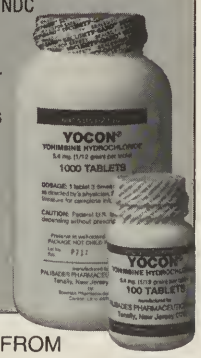
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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because of the malpractice situation. In one teaching hospital, three out of four neurosurgeons had left prematurely, or had taken jobs at government hospitals."

He continued, "The governor was always willing to listen. He didn't always agree with us, but he was interested in our concerns and how they reflected on the public's interest. That was a great contrast to some of his predecessors."

Jeffrey Miller, the governor's current chief of staff, commented, "He was clearly instrumental in the [malpractice] issue, which pitted physicians against lawyers. He recognized the seriousness for physicians and patients, and was willing to put his prestige on the line and push for a legislative package."

Improving medical discipline

Following the 1985 tort reform initiative, Governor Thompson challenged physicians and attorneys to upgrade professional discipline within their professions, and called for a task force to reform the state's Medical Practice Act. Dr. Clementi, who chaired that task force, recalled that "Governor Thompson encouraged us to look at the medical disciplinary process and improve the mechanisms. He was significantly helpful in involving physicians and improving the disciplinary process."

Public aid advancements

Public aid issues have always placed high on Governor Thompson's agenda. Arthur Quern was Thompson's first director of public aid, appointed as part of the governor's 1977 "health cabinet." "From the beginning, the governor understood that health care for the poor was very important if we were to get people off welfare," Quern remembered.

He was also committed to fair public aid reimbursement for physicians and fighting Medicaid fraud, noted Quern. "The biggest obstacle [when Thompson entered office] was the legacy of Medicaid fraud, which had so tainted the program that it was impossible to improve the fee structure for physicians and hospitals, or to remedy the situation while people felt vast amounts of money were being wasted."

A state crackdown on "the clinics and physicians who were misusing the system" resulted. "Some felt this was just another anti-welfare move, when in fact it was an attempt to clean up the program and build confidence," Quern said. Thompson recognized the need for additional public assistance revenues. He repeatedly called for boosts in public aid funding, via proposed state income tax increases in 1987, 1988 and 1989. The recent funding increase was accomplished under Thompson's aegis.

James "Pate" Philip, state senate Republican leader, commented, "Under Governor Thompson, the state has been a leader in providing medical services on a number of fronts. We are providing more and better medical care to the poor than ever before." Thompson has also "maintained a commitment to the small providers—those that are responsible for the everyday health and well-being of a majority of Illinoisans," Sen. Philip said.

Miller also pointed to the Comprehensive Health Insurance Program (CHIP) launched in 1989, for people who would otherwise be unable to obtain coverage and the governor's creation of the Illinois Health Care Cost Containment Council.

Public health progress

According to Bernard Turnock, M.D., Thompson's current director of the Illinois Department of Public Health (IDPH), the governor has "clearly been able to recognize the link between economic development and community personal health. You can see a commitment to disease prevention, and children."

Infant mortality reduction is a major Thompson focus, said Dr. Turnock, stressing that despite Illinois' higher rate than the nation, the state's infant mortality rate was reduced 45 percent from 1975, the year before the governor was elected, until 1988. Thompson also earned national recognition for Illinois' programs to reduce teen pregnancy and increase adolescent support services, he noted.

State health department funding resources have "almost doubled" under Thompson, said Dr. Turnock. Thompson created the Department of Alcohol and Substance Abuse (DASA) as a separate agency, indicating a strong commitment to disease prevention strategies for tobacco, alcohol and drugs," he said.

In Dr. Turnock's view, access to care will be a major issue for Governor Thompson's successor. "It may be the overriding problem." He also sees the fight against AIDS, infant mortality and drugs as "immense challenges for us after Thompson moves out of the public sector."

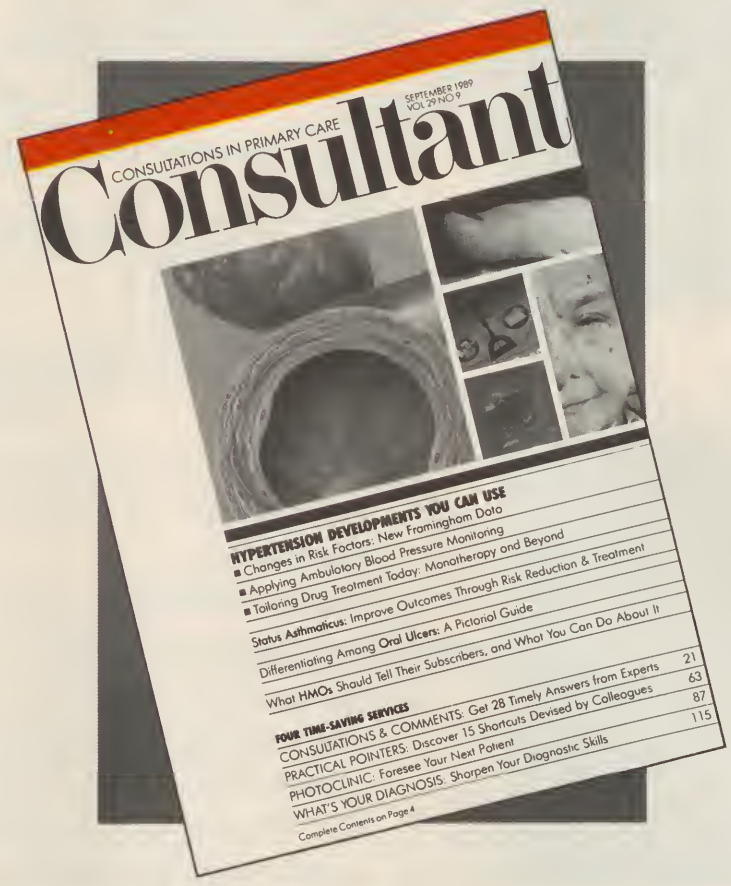
The effects of Thompson's departure are "yet to be sorted out," Quern added, "but the next governor will be forced to deal with [health care] whether he likes it or not, because the federal government will push these issues down to the state level."

Democrats' view

Those across the political aisle also credit the governor's health care record. According to Rep. Jesse White (D-Chicago), "Even though we're from different parties, [I think] he has been sensitive and concerned about health care for people across Illinois, and a number of meaningful pieces of legislation have been pushed through with his support."

A spokesman for Speaker of the House Michael J. Madigan (D-Chicago) declined to comment specifically on the governor's health care record, but said Thompson has "had the highest level of respect, personally and professionally" during his career. ▲

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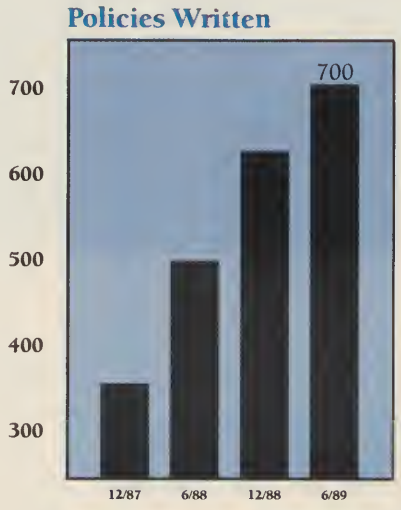
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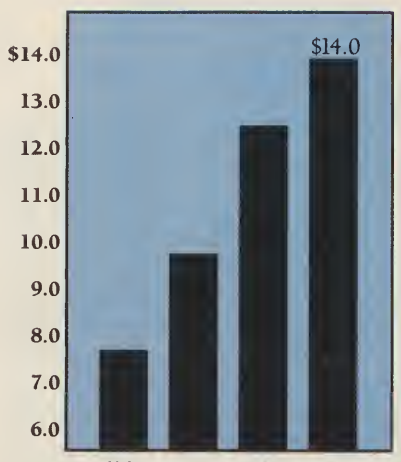
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(continued from page 2)

of O positive blood. "We were able to meet the needs of the trauma victims, but on Monday morning, we had no O positive blood on the shelves," she says.

Summer vacations add to the problem

At the same time that demands for blood go up, sources of blood virtually dry up. "X percent of the population is on vacation between the middle of June and the day after Labor Day, and this has two effects. It distracts people, as individuals, from donating blood. And industries and corporations that commonly sponsor blood drives are somewhat reticent to have blood mobiles come because time that staff have to be away from work giving blood puts a further burden on already short staff," says Richard Sassetti, M.D., chairman of the Illinois State Medical Society's (ISMS) Committee on Blood Banking and Laboratory Services.

Some major sources of blood donation simply are closed down during the summer. "Some main suppliers in the winter months are Illinois State University and Illinois Wesleyan University. During two days of Greek Week, we can get as many as 200 units of blood a day, and at other times, we can get 150 to 175 units a day at the universities," says Jean Fouts, president of the Illinois Society of Medical Assistants, Inc., and health history nurse for the Peoria area blood-mobile. But, she points out, those units of blood are all but lost in the summer.

Media appeals can help

Major media appeals are a mainstay for blood centers in times of crisis. When a stabbing victim in Peoria requiring 250 units of blood depleted the region's supply of O positive blood, a blood drive was held at College Hill Mall and the response was unbelieveable, Fouts says. "We started at 5:00 in the evening, and it took until midnight to draw blood from all the people who came," she remembers.

The national Red Cross also has a cadre of regular blood donors to blunt the effect of periodic shortages. New to the heart of Illinois region, which includes all of central Illinois, is the VIP program, which requires individuals to give blood four times during a 12-month period.

Donor recruitment programs have been stepped up in the last few years primarily because of AIDS. "Six months to a year after news about AIDS really broke, there was an estimate that blood donations were down by about three to five percent," says Dr. Sassetti.

Donations rising

Donations have been on the rise since then. Donors have increased from four to seven percent of the population of McLean County, says Kancius. And the Chicago area has been able to keep donations at an acceptable level, says Ennio Rossi, M.D., vice president of LifeSource, Glenview, and professor of medicine, Northwestern Medical School, Chicago.

However, encouraging blood donations has required vigorous donor recruitment. As Dr. Sassetti notes, "The irrational concern that a person could get AIDS from a blood donation" seems to have abated. Nevertheless, "my blood donor recruiters tell me there is still a general discomfort about giving blood," he adds.

Dr. Rossi stresses that the blood supply and the process of giving blood have never been safer. Only 15 to 18 units of blood donated last year in the Chicago area were positive for the human immunodeficiency virus; only 10 to 14 units have been found positive for HIV in McLean County since 1985, says Kancius.

Screening precautions observed

Donors themselves are carefully screened; and blood samples are extensively tested. "All blood centers in December began testing for HTLV-I virus, which is associated with two very rare diseases, and in the next year we should have a new test that will identify anywhere from 60 percent to 70 percent of the undefined hepatitis, the hepatitis non-A and non-B," says Dr. Rossi. These are examples "of how blood services in the country are going to extreme lengths to make the blood supply as safe as possible," he notes.

In addition, individuals now have alternatives to standard blood transfusions. Autologous donations, drawings of blood from patients who will have certain types of elective surgery in upcoming months, appears to be doubling every year, says Dr. Sassetti. And intraoperative blood salvage is becoming more widespread. "It has been done for decades in all major teaching hospitals in Chicago, and LifeSource programs established in the last year are trying to make arrangements with other hospitals so we can provide the service to them," says Dr. Rossi.

Finally, steps have been taken "toward a wiser use of this invaluable resource," he adds. Consensus conferences by the National Institutes for Health have spelled out for blood service specialists and practicing physicians the uses of plasma, platelets, and red blood cells. "We are taking into consideration the fact that transfusions will never achieve a zero risk status," Dr. Rossi says. "Therefore, we must always avail ourselves of different alternatives to homologous transfusions and strive to make the homologous supply as safe as possible." ▲



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types of wastes, including sharps, she said regulations on waste disposal should be based on scientific principle, not public perception.

The nation's largest manufacturer of biohazard and chemotherapy waste containers, Sage Products in Cary, has seen an increase in the demand for its products, according to Paul Hanifl, director of product development. Hanifl attributed the demand to concerns about transmission of AIDS and hepatitis.

An editorial published in a 1988 issue of *Infection Control Hospital Epidemiology,* stated, "Studies indicate that the bacterial concentration of different types of hospital waste has 10 to 100,000 times less microbial contamination than household waste." The author, Eddie R. Hedrick of the University of Missouri-Columbia Hospital and Clinics, maintained that federal, state and local documents written to address medical waste have had good intentions but often have not included scientific risk/benefit analysis.

Developing alternatives

Dr. Dieter said any ordinance regulating medical waste should be developed through input from the whole community, including physicians, waste managers and private citizens.

"I'd rather not have it be a political thing from the word go," he said.

In the past, some physicians have solved the problem of waste disposal by hauling their wastes to hospitals that have incinerators on site. Fear of liability, though, has made some hospitals less willing to accept such wastes.

Asked how he thought the DuPage County ordinance banning sharps from its landfills addressed the problem of how to dispose of these materials, Dr. Dieter said, "If they turn you down, it's not addressing it at all."

Emmerman said hauling waste out of a county or even out of state is not uncommon.

But people are becoming less willing to let the communities and states in which they live become dumping grounds for other people's waste. Although public concern over safety has focused attention on medical waste, with landfill space quickly filling up, it is not just potentially harmful medical waste that is the problem, but also general waste as well.

The issue concerns both where and how to dispose of waste.

Incineration can reduce the amount of space waste takes up, but it can also put pollutants in the air. Improperly maintained landfills can contaminate the groundwater.

"Incineration isn't safe. Landfilling isn't safe," Hanifl said. The alternative is to "reprocess" waste.

Watson agreed that recycling may be one way to cut down not only on the quantity of general waste but of medical waste as well.

"I don't think hospitals have looked at that," Watson said.

Whatever the solution, physicians and other health professionals can continue to expect to be held increasingly more responsible for the waste they produce. ▲

What MDs are doing about waste disposal

The Illinois State Medical Society (ISMS) has been invited to participate in the Medical Waste Tracking Study Group that will review state laws on medical waste.

Gov. James R. Thompson first announced plans for the group in April at the same time that he indicated Illinois was opting out of a federal program to track medical waste. ISMS had expressed its opposition to the federal program in February testimony before the Illinois Environmental Protection Agency and a letter sent to the governor by Harold L. Jensen, M.D., ISMS chairman.

In his letter, Dr. Jensen criticized the federal act for not distinguishing between infectious waste and medical waste, and for being too costly. In addition, he noted that Illinois already has a program in place for tracking medical waste. The program requires Illinois hospitals to complete a five-part tracking form for infectious medical waste.

The federal act would have required most physicians to participate in a similar tracking program.

In the absence of federal or state laws, however, some physicians still are beginning to contract with special waste haulers to dispose of sharps and other potentially hazardous medical waste.

Russel Karlins, vice president at the Oak Brook, Ill.-based Medical Disposal Services, estimated that 80 percent of physicians are just throwing sharps and bloody gauze in the garbage can. Karlins noted, though, that an increasing number of physicians are starting to take a more cautious approach to waste disposal in an effort to protect their staff and decrease their liability risks.

Michael S. Popper, M.D., an internist in Lombard, Ill., said he first started looking into special waste hauling services last February when he found out that the county had developed guidelines for what medical waste it would accept in its landfills and how the medical waste it did accept had to be packaged.

"Now all of the sudden [with the county regulations] you have to be an expert overnight," he noted.

Dr. Popper eventually settled with Medical Disposal Services. Like many disposal companies of its type, the company provides clients with special waste containers, hauls the waste, brings it to an incinerator and provides the generator with a certificate of destruction.

Contracting with a special waste hauler meant only a few changes in Dr. Popper's office. One of the center's servicing labs already was picking up sharps for disposal, and they were taking precautions with the disposal of other items such as open pharmaceuticals and dirty dressings. In addition to these controls, they now have two wastebaskets in almost every area of the office to separate potentially hazardous medical waste from general waste.

If anything, he said, they're probably erring on the side of being "over-secure." ▲

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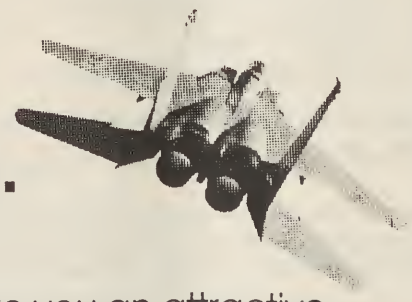
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Physician assistance program helps families 8

Illinois Medicine

August 18, 1989 ILLINOIS STATE MEDICAL SOCIETY

Measles outbreak still on upswing

IN A MOVE to combat the measles outbreak felt most heavily in Chicago, the Illinois Department of Public Aid (IDPA) is permitting reimbursement to Chicago health care providers for immunizing Medicaid eligible children ages 6 to 15 months for measles.



Richard M. Krieg

The number of reported measles deaths in the state has climbed to six as of August 8, with five of the fatalities occurring in Cook County and one in Du Page County.

Since the state's first reported measles case in February 1989, the measles outbreak has hit Chicago the hardest compared to any other Illinois city or county. The total number of confirmed measles cases in Chicago has reached 816 as of August 7, according to the Chicago Department of Health (CDH).

IDPA recommends children ages 6 to 12 months should receive a single antigen measles vaccine (procedure code W7580) and children age 12 months and older should receive a measles, mumps and rubella (MMR) vaccine (procedure code W7583). IDPA officials note "children previously immunized against measles are not to be re-immunized and IDPA will not reimburse for re-immunization." IDPA's emergency procedures apply only to children residing in Chicago, and will be in effect until the Illinois Department of Health (IDPH) declares the measles outbreak over.

Providers can obtain billing instructions about immunization by contacting IDPA at 217-782-5567.

Ralph March, section chief of IDPH's immunization program, urges all hospital employees with direct patient contact should be immunized against measles.

Richard M. Krieg, Ph.D., CDH acting health commissioner, emphasized, "It is essential that preschool children in areas with high levels of measles cases get immunized." Infants 16 months to four-years old account for nearly 80 percent of the city's measles cases, "a situation which reflects the difficulty of reaching this age group with protective vaccine," warned Dr. Krieg.

Noting that the epidemic has "not yet peaked," Dr. Krieg said a 2-year-old boy and a 12-month-old girl, both from the North Lawndale area, died earlier this month from pneumonia caused by measles.

Another seriously ill 2-year-old suffers from encephalitis caused by measles and may face brain damage if she survives, added Dr. Krieg.

A nine-month-old west side boy and a 30-year-old south side man also died of measles-induced pneumonia last month.

In the northwest suburbs of Cook County, a 10-month-old girl died earlier this month of an inflammation of the brain caused by measles and a 32-year-old nurse from the far west suburbs died May 31 of a stroke, respiratory collapse and kidney failure induced by measles, according to March. ▲



S.I.U. photo by Diana Kleidon

Representatives from Illinois communities and organizations searching for physicians will meet with medical students and resident physicians during the eleventh annual Doctors Fair at Southern Illinois University School of Medicine in Springfield between 10 a.m. and 2 p.m. Friday, Sept. 8. The fair is hosted by Springfield's Memorial Medical Center and co-sponsored by the Illinois Academy of Family Physicians, the Sangamon County Medical Society and the Illinois Hospital Association.

Part one of a series

Medicare's PRO walks a 'fine line' in Illinois

THERE'S HARDLY a physician in Illinois who isn't familiar with Medicare's peer review organization (PRO). Its mere mention often gives rise to strongly-voiced opinions by MDs. Has the PRO program earned a reputation as Medicare's zealous cost cutter and physician nuisance? Or are physicians overreacting, wanting to "kill the messenger" without a clear view of the facts?

In this first of a series, *Illinois Medicine* looks at Medicare's PRO, and what it's doing for and to Illinois physicians.

Founded in 1974, Crescent Counties Foundation for Medical Care (CCFMC) served for eight years as one of several professional standards review organizations (PSRO) reviewing physician Medicare services in Illinois before becoming the statewide peer review organization (PRO) in 1984.

The Medical Environment

A periodic observation on issues and trends affecting modern medical practice, and the challenges they present.

History and mission

1984 served as a milestone for Medicare. The federal government's imposition of a radically new hospital reimbursement scheme—diagnosis related groups (DRGs)—heightened the need for strong review and enforcement in the Medicare program. While PSROs had done some of that, the adaptation to a single PRO strengthened the focus on assuring appropriate utilization and quality care for Medicare beneficiaries.

The PRO can issue denials of Medicare payment to MDs and hospitals when it sees inappropriate use of medical resources. It can recommend sanctions for those flagrantly abusing Medicare rules—or practicing substandard medicine. It validates hospital DRG coding, and can change it, if warranted.

"It was the government's buffer, that with the implementation of DRGs' flat payments to hospitals, patients wouldn't be short changed," explains Alfred J. Kiessel, M.D., a Decatur pathologist who serves on the Illinois State Medical Society's (ISMS) board of trustees and as a consultant to the ISMS Council on Economics, which monitors the Medicare PRO. "It was a club to change how doctors and patients viewed

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North Shore IPA to dissolve after three years; now negotiating settlements with 300 doctors

by Frank Kourt

A 300 MEMBER independent practice association (IPA) located in the upscale and affluent Chicago North Shore area is planning to dissolve after three years of operation, due to financial troubles.

According to Walter R. Grebelny Jr., M.D., chairman of the board of directors of the IPA, known as the Physicians' Association of the North Shore (PANS), it has terminated all HMO contracts and is working on a negotiated settlement to its approximately 300 North Shore physician members. Like other IPAs, PANS was formed by physicians to give its membership an opportunity to negotiate directly with HMOs through its board of directors.

The North Shore, so-called because of its location on the shore of Lake Michigan in an area north of the City of Chicago, is composed of some of the most upscale communities in the Chicago area and, according to some, this very fact may have contributed to PANS' financial problems because of the traditionally high utilization rate of outpatient services by affluent residents.

"Basically, there's about a million dollars in capital on hand and there are about $3.5 to $4 million in physicians' charges that we have certified as being legitimate," said Dr. Grebelny.

According to Dr. Grebelny, the IPA, founded in 1985, had contracts with HMO Illinois, Maxicare, Choice and Access.

IPA's problems stemmed from a "mismatch"

Dr. Grebelny said the IPA's financial problems stemmed primarily from "a mismatch between utilization and income," adding that while the IPA met inpatient utilization goals, outpatient utilization was a problem.

"It's still hard for us to tell after three years of operation with negative results what the whole problem was. Our best understanding is that the insurance companies' expectations of outpatient frequency of service and their expectations of expenses for those services were significantly different than what the physicians' expectations were," said Dr. Grebelny, adding that there were also misconceptions on the part of the physicians about the amount of utilization review needed.

"I think that we didn't understand exactly how much we were supposed to limit outpatient services. Most of our physicians were involved in a minority extent of their practices. They paid careful attention to the fact that the contracts called for them to treat these [HMO] patients the same as their fee for service patients, so that if a person would call and ask for a service, they pretty much got it. There wasn't that 'policeman' type of restriction of activity on the outpatient side," he explained.

He advised physicians who are involved or becoming involved with IPAs to "pay very careful attention to the demographics of the population and [do] some independent verification of what utilization experience might be predicted to be." Dr. Grebelny also recommended that IPAs have concurrent and active tracking of utilization and they should carefully track income.

A targeted settlement date for payment to North Shore IPA physicians is set for September.

"We've been working with this for a period of months and all parties and the attorneys have done an heroic job of getting everyone's agreement and understanding of the situation. Everybody's been quite cooperative," Dr. Grebelny said.

Physicians were paid on either a capitation or discounted fee for service basis, depending on the individual HMO contract, Dr. Grebelny said.

Attorneys are optimistic on equitable settlement

Barbara Mayers, an attorney with the Chicago law firm of McDermott, Will and Emery, is working on the voluntary dissolution of PANS and is optimistic that an equitable settlement can be worked out.



"We are working on determining PANS' assets and liabilities with as much specificity as possible," Mayers said, adding that physician members of PANS are being kept abreast of the situation and will be informed of the percentage of outstanding claims they would receive under a voluntary dissolution when all the figures are in. She said all of the approximately 300 physicians to whom money is owed will have to agree on the settlement in order for it to take place. She said the last of PANS' contracts with HMOs were terminated as of April 30.

Mayers said the board of directors of PANS felt that voluntary dissolution was the best and fairest of the alternatives facing PANS, others of which include filing for bankruptcy or going for a court supervised dissolution.

She confirmed that PANS is working on a settlement with Evanston Hospital, to which it also owes money. The hospital was responsible for business systems and accounting for the IPA in recent years.

Mayers said it's impossible to know the exact cause of PANS' financial problems. That would take a systematic analysis and evaluation and because of the expense involved in undertaking such an analysis, it would make no fiscal sense to do so at this point. *Illinois Medicine* was unsuccessful in numerous attempts to contact a representative of Ernst and Whinney, an accounting firm used by Evanston Hospital to assist with PANS' accounting.

Physician members tell their story

M. LeRoy Sprang, M.D., an obstetrician and one of the members of PANS, said his six member group is owed "in the range of $150,000" by the IPA.

He said most of the physicians in his group joined the IPA out of loyalty to Evanston Hospital, which would benefit by admissions through HMOs.

"I think probably many physicians on their own simply join IPAs or HMOs because everybody is afraid that if they don't, they'll be left out," he commented. Like Dr. Grebelny, Dr. Sprang said he estimated that most PANS members' practices did only about 10 percent of their business as a result of the IPA's HMO contracts.

He said many of the PANS board of directors members are friends of his and he believes they simply did not realize there were financial problems until they were too big to deal with.

"They didn't have a good handle on the finances, to really know which bills were coming in and how much money was coming in to cover those bills," said Dr. Sprang.

Dr. Sprang said that in some cases the IPA was as much as a year behind in paying physicians.

"From the physicians' point of view, I think we were naive in continuing to stay with a plan that was that far in arrears in paying its debts," said Dr. Sprang, who vowed never to become involved with IPAs or HMOs in the future.

For those who are involved or are planning to become involved in such ventures, Dr. Sprang cautioned that if the IPA is more than three months late in paying its debts, physicians should "either get a very solid explanation or quit, because you're just asking for trouble as more and more time goes by and you're left holding a bigger and bigger bag."

He added that prior to starting an IPA, he feels physicians should institute an independent study of what the insurance company will pay and what the costs will be, and "not rely on the HMO. The HMO is going to paint a rosy picture whether it's accurate or not."

Dr. Sprang also cautioned that physicians contemplating such a venture should not take the HMO's word that if they can stay within a certain hospital utilization they'll be fine and profitable. "And that's what they [PANS] did. They just took the HMO's word without having any information of their own on which to base that," he said.

An experiment that failed

Arnold Wagner Jr., M.D., another obstetrician member of PANS, called the experience with the IPA "an experiment in socialized medicine that failed."

(continued on page 11)

Physician Facts

Hospitalization Costs of Illinois AIDS Patients

Overall Cost of Hospitalization: $18.2 Million

Number of Admissions	2
Length of Stay per Admission	16 Days
Total Length of Stay	33 Days
Cost per Day	$ 1,089
Cost per Admission	$17,612
Total Cost per Patient	**$36,317**

Based on an IDPH study of 500 people diagnosed with AIDS and treated from April 1982 to September 1987. Figures shown represent the mean.

Source of Data. Illinois Dept. of Public Health, June 1989.

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Abortion issue divides Rockford community

by Denise M. Showers



Jon McGinty

THE U.S. Supreme Court decision in the Rockford-based *Turnock* v. *Ragsdale* case, scheduled to be heard this fall, could significantly impact women's health care services in Illinois. If Richard Ragsdale, M.D., loses his case, his Northern Illinois Women's Center (NIWC), the only abortion clinic in northwestern Illinois, could be forced to close its doors. That prospect makes some Rockford physicians nervous.

"I don't think there's a civil society anywhere that wants to return to backroom abortions," says Robert Bertrand, M.D., president of the Winnebago County Medical Society. "That's the threat we're dealing with here."

Closing the clinic would leave the options of illegal abortion or seeking the procedure elsewhere. Without the clinic's availability, say area physicians, it is probable that women who can afford to travel to other cities and pay the fee for an abortion there will choose that option.

"We'll have to refer to clinics outside the community," says Dennis Norem, M.D., an internist at Rockford Clinic. "Some of my patients prefer to go out of town anyway, because of the constant picketing [at NIWC]." Women of means can go elsewhere to abort, while poorer women will have to choose between illegal abortion and bearing an unwanted child, according to Dr. Norem.

The Rockford medical community is divided as to whether the city's public attitudes toward abortion are unique or whether they reflect national opinion. Some physicians, who requested anonymity, believe Rockford is strongly "pro-life," while others think the "pro-choice community has been a silent majority."

As one indicator, thirty-five members of the Coalition for Reproductive Choice marched in Rockford's annual Fourth of July parade this year, a forum reserved in the past years for pro-lifers. Coalition members now congregate across the walkway from pro-lifers demonstrating at NIWC everyday. The coalition is there to support and escort women who come to the center for abortions or counseling.

Kate Traynor, R.N., stands alone, holding a pro-choice sign near the entrance gate to the clinic's parking lot. Often, she says, she is accompanied by a dozen peers who try to counter the pro-life picketers. "I don't think these [pro-life pickets] change anyone's mind, although they think they do," says Traynor. "They just infuriate the women who see them out here." Patients tend to "become enraged and barrel right into the parking lot," she added.

June Taylor, director of public and professional relations for the Winnebago County Medical Society, says, "The lines are drawn more sharply in Rockford. People here really dig in their feet on both sides of the issue. This is a very church-oriented community, and that includes a large pro-choice community."

Clearly, though, the abortion issue and possibility of the clinic closing are not openly discussed among Rockford physicians, according to those who spoke with *Illinois Medicine*. "The medical community here has tacitly agreed to respect everyone's views," says Dr. Bertrand. "The issue rarely gets debated here because we have an [abortion] clinic where there is no question about the competence of medical care."

"Since access has not really been affected yet," says Dr. Norem, "[the effects of a Supreme Court ruling] haven't sunk in. We are preoccupied with economic issues, like new Medicare restrictions. That's what's having all the emotional impact here."

Not surprisingly, Rockford physicians aren't discussing abortion with the media, either. Heads of hospital OB/GYN departments abruptly became unavailable for comment, when contacted by *Illinois Medicine*. St. Anthony's flatly declined, citing the issue as "too touchy" for a Catholic hospital.

Helen Doyle, a pro-life picketer who has stationed herself outside the Rockford clinic nearly every day since it moved to its current location in 1985, commented, "So far today, there's been 16 [patients] going in there." She points to the piece of paper where she's tallying comings and goings at the clinic. Doyle says her group, which numbers from ten to twenty pro-life supporters daily, has no official name. "It's just a bunch of people from all different churches. If the clinic closes down, and it might have to, then we'll say 'Thank you, Lord, for small favors,'" says Doyle.

Two young women cross the street toward the clinic, stop short, stare at

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Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

IMPORTANT BILLING INFORMATION FOR THE MPP/PPO PROVIDER

The following information is provided to highlight the billing requirements of Blue Cross and Blue Shield of Illinois' (BCBSI) MPP/PPO programs:

MPP PARTICIPANT

The Mutual Participating Provider program (MPP) contract specifies that the physician/provider bill BCBSI only and not the BCBSI subscriber for services that are contractually eligible under the subscriber's usual and customary contract. While the provider may bill the subscriber for contractually ineligible services and for any deductible or coinsurance amounts payable under the contract, the provider accepts BCBSI's usual and customary fee determination as full payment for contractually eligible services.

For example, if the usual and customary allowance is $500.00 for a billed service and there is a 20% coinsurance amount to be paid by the subscriber, BCBSI will issue a $400.00 payment and the subscriber will be responsible for the remaining $100.00.

PPO PARTICIPANT

The PPO Provider bills BCBSI only and not the BCBSI subscriber for services that are contractually eligible under the subscriber's PPO contract. While the provider may bill the subscriber for contractually ineligible services and for any deductible or coinsurance amounts payable under the contract, the PPO provider accepts the lesser of BCBSI's PPO Schedule of Maximum Allowances or the provider's fee as full payment for each service covered under the subscriber's contract.

For example, if the lesser of the maximum allowance and the provider's fee for a billed, eligible procedure is $500.00 and there is a 20% coinsurance amount to be paid by the subscriber, BCBSI will issue a $400.00 payment and the subscriber will be responsible for the remaining $100.00.

(This report is a service to the physicians of Illinois)
8/18/89

Editorials

Helping medical families, helping the profession

When physicians have a medical problem that needs attention, they're frequently the last ones to admit it or seek help. Like the general public, physicians in trouble due to physical or emotional illness too often try vainly to deny or hide the problem, putting additional damaging stress upon themselves and their families.

As one innovative and effective remedy, the physician's assistance program established by ISMS more than a decade ago boasts a creditable record of accomplishment. This multi-faceted intervention program—conceived and directed by expert physicians themselves—enables more than 80 percent of the doctors who seek help to return to productive, satisfying professional and personal lives. And, the program's support, reassurance and pragmatic assistance provided to medical families has proved to be an enormous side benefit.

The program's success is based on the tenet that troubled physicians can be helped to acknowledge their problem, face it squarely and overcome it with the help of confidential, highly qualified assistance and a supportive family. The program demonstrates that a physician's talents, professional skills and interpersonal relationships can be restored and invigorated. And that's good news for everyone.

Digesting "alphabet soup"

Physicians confronting affiliation with HMO, PPO, IPAs and other entities are often overwhelmed by the legal "mumbo-jumbo" couched in their membership contracts. Physicians in alternative health care delivery systems recognize that a well-prepared, clearly understood contract produces different results than one hastily signed and dimly understood.

The key is to understand precisely the terms of any contract that's signed, and the liability and financial exposure incurred as a result. Before signing any binding contract, review it carefully with your personal attorney, or with a legal specialist in the issues the proposed contract sites. ISMS can provide recommendations of knowledgeable attorneys.

The health care system is in the process of dramatic change. Clearly, health care financing arrangements are, and will continue to be, more diverse than in the past. Change can mean disaster, but it can also signify opportunity. Understanding how diversity and change affect you and your patients is key to coping in the new environment. ▲

Illinois Medicine

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"Long shift?"

President's Column

Helping patients get wishes granted



Eugene P. Johnson, M.D.

We physicians agree with our patients' quest for control over their own lives. Indeed, someone truly active in his or her own decision-making about treatment of a condition or illness makes the best patient.

One concrete way which we physicians can support our patients is by learning as much as we can about two legal tools that spell out steps to take when a patient is in a terminal condition: the living will and the durable power of attorney.

The living will and durable power of attorney laws allow an individual to express his or her wishes about being kept alive through artificial means, and the law allows patients to mandate what life sustaining measures should or shouldn't be taken. Under the durable power of attorney law, a patient can appoint a "health care agent" who, in effect, makes all medical treatment decisions for them once they have become incapacitated.

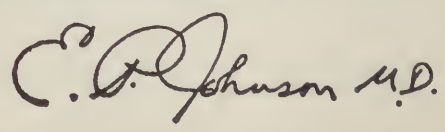
One way to make sure a patient's wishes are followed is to have both documents in the medical record. This year, the ISMS House of Delegates approved the concept that persons having living wills and durable power of attorneys should carry a card stating that these documents exist and where they are on record. Further, the House directed that ISMS strongly recommend to hospitals and physicians that they accept and act on the documents. The laws provide options for physicians who do not wish to carry out the instructions in the documents, and immunities for those who comply with the patient's directives.

A patient can use both documents to give the physician, the patient's family and friends a clear path to follow in the event the patient is unable to speak for himself. The presence of the documents removes the burden of decision making from distraught family members and places it in the patient's hands. Laws governing both documents spell out protection for physicians acting in good faith and with due care for the benefit of the patient, and in accordance with the patient's wishes.

ISMS is preparing a pamphlet which is intended to help physicians understand the Living Will Act so they can answer patients' questions about the law. It is available from the division of Education and Medical Services at ISMS, Twenty N. Michigan Avenue, Suite 700, Chicago, 60602. Another pamphlet on the Durable Power of Attorney law will be out early in 1990.

Not all physicians or patients agree with exercising living will and durable power of attorney options. Physicians should not advocate for or against patients making use of either of these documents. Nor should a physician help a patient complete either document. What a physician can and should do is know about the laws governing both options and discuss those options when a patient expresses a desire to have certain procedures followed.

Using the ISMS information will help both physician and patient discuss the subject. And, once completed and in the patient's medical record, the existence of such documents can ease the minds of our patients and allow them to go about the business of living. ▲



Eugene P. Johnson, M.D.
President

Guest Editorial

The IPA quandary



by Judee Gallagher

INDIVIDUAL PRACTICE associations (IPAs) are no place to hide from financial risk. Chicago area physicians learned this first hand when Physicians Association of the North Shore (PANS) ceased operations, owing its physicians millions of dollars for HMO patient care. Like many area IPAs, PANS contracted with large HMOs including HMO Illinois, Choice and Access. PANS' inability to pay its physicians was not the result of the HMOs' failure to pay PANS. If the HMOs were paying PANS, why, despite hard work and good intentions, couldn't PANS pay its physicians?

There are no easy answers because IPAs are complex businesses. HMOs love them because it's an effective way to shift financial risk to physicians. Concurrently, many physicians believe that their IPAs can keep things they don't like about managed care systems at bay. Realistically, survival of the IPA may require IPA enforcement of the very system its members are seeking to avoid. Whenever an IPA is paid by capitation fee, it accepts the risk that if its utilization rate or cost for providing services is higher than anticipated, it will lose money.

The IPA's cost of providing services is largely based on its payment scale for physicians' services. IPA director-physicians make tough choices about how physician-members will be paid. The challenge is how to divide the capitation payments between primary care, specialists and ancillary providers, leaving enough to pay administrative costs. How does the IPA convert the capitation payments it receives into a fee schedule? Unfortunately, there are no tried and true rules or formulas. Trial and error (or terror) appear to be the best teacher and the learning process has been painful.

Some IPAs pay primary care physicians a capitation fee and specialists according to their fee schedule. Accordingly, physicians are operating under contradictory economic incentives. Those paid by capitation receive a fixed dollar amount regardless of utilization. Income increases as utilization decreases, while income increases as utilization increases for the specialist. Regardless, when utilization exceeds a point, the IPA will lose money and eventually *no one will be paid.* Enforcing a workable utilization control program is as difficult, and just as critical as determining the payment schedule.

In addition to mandatory prior authorization, some IPAs compile physician utilization profiles. When a physician's practice patterns result in consistently high utilization, the IPA takes action. With the understanding that managed care simply is not for everyone, the physician may eventually be asked to leave the IPA. Many IPAs include in their contracts the right to impose financial penalties and deny payment for over-utilization but most admit to never having used the penalties. One popular, but arguably ineffective, way to control utilization is to withhold a percentage of physicians' fees. The withheld fees are forfeited if utilization exceeds targets. Since, in practice the physicians rarely seem to get a withhold back, the threat is without "bite." Some experts believe that the best incentive to control utilization is to pay physicians by capitation.

In spite of the above, it turns out that no business can survive without accurate information. Basic accounting requires a matching of income and expenses. However, due to poor accounting controls, many IPAs never know that they're in trouble. The HMO's cash flow during periods of growth is ahead of claims submitted. When the process levels off, there is trouble. Some IPAs do not require physicians to submit claims promptly.

An IPA needs to know whether it is making or losing money on each HMO contract. It needs to know if a contract or particular type of service or treatment is draining its resources. The HMO can include expensive treatments as a covered service when the IPA pays—no problem for the HMO. Without information regarding the cost and utilization of providing services under each contract, the IPA may be no better off than an individual physician in negotiating contracts.

If all these responsibilities were not enough, many IPAs also operate in the thick of hospital politics. Some depend on hospitals for financing and access to expensive management information systems. What's best for the hospital may not be best for the IPA. A hospital may wish to contract with an HMO to protect its market share. Since hospitals and IPAs compete with each other for premium dollars that HMOs allocate to pay providers, who should negotiate with the HMO first? Dreaming, one physician observer noted that if the physicians had staff privileges at more than one hospital, the IPA could contract with HMOs for the entire provider premium and then the IPA could negotiate contracts with the competing hospitals. ▲

Ms. Gallagher is a private practice attorney representing physicians in health care legal matters. She was counsel to the former ISMS Office of Contractual Services.

Letter to the Editor

"Dear Doctor" response

I'd like to reply to Mr. Gerald Prete, whose guest editorial appeared in the July 21 issue of *Illinois Medicine*.

The proposal that physicians in Illinois work in harmony with the state's senior citizens is right on target. Most physicians work in very close harmony with their older patients today, and have done so throughout the recorded past. So that our mutual desire for quality care of those patients may continue and indeed flourish, there are some facts relating to [Mr. Prete's] recent guest editorial in *Illinois Medicine* that I believe he should look at with openness and understanding befitting his experience and commitment.

First, someone has misinformed Mr. Prete about physicians who accept and do not accept assignment.

Forty-one percent of physicians accept assignment always. Most of those who do not always accept assignment will when asked to do so by the patient. Now, we know that no one is under any obligation to see a physician who refuses to accept assignment. We also know that our government spends thousands of dollars to publish and distribute lists of doctors who do accept assignment.

Secondly, I don't think he's heard of MAACS.

I won't try to explain how MAACS are conceived. Medicare has tried and failed to explain that fact of life to me; so I lack the audacity to explain what I can't understand to him. I can tell him all about how they are delivered, however.

MAACS limit the fees I may charge my private patients to amounts less than Medicare allows for physicians who accept assignment. Mr. Prete might be interested to learn that about two thirds of all monies paid to doctors by Medicare are paid by assignment.

Fees of doctors who accept assignment always are allowed to be increased at a greater rate, and they are paid more promptly too.

Our fees are set by law—often, as he observes in his editorial, bureaucratic incompetence has resulted in fee levels which are unjustly low. But fees may not exceed the MAACS. That's the law; so whatever Illinois doctors were paid in 1987, it was only what the bureaucrats allowed, and no more. The amount noted as excessive wouldn't buy one wing for a stealth bomber.

Now, lastly, about the ninety year old woman from Pekin, somebody didn't tell Mr. Prete the whole story. No one is entitled to $17,000 for a corneal transplant operation. If there isn't more to that story than he's telling us, she shouldn't pay that bill anyway, because that ophthalmologist won't need the money. He'll be in jail.

James E. Cassidy, M.D., F.A.C.P.
Oak Brook

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Challenges and Choices For the 1990s

Friday Evening, November 17, 1989

6 p.m. Cocktails and Dinner
Speaker
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Saturday, November 18, 1989

7:30 a.m. to 4:30 p.m.
Luncheon Speaker
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Defend or settle?

by Fred Z. White, M.D., Chairman, Illinois State Medical Inter-Insurance Exchange

The first of two articles on professional liability issues.

AN IMPORTANT decision facing physicians and insurers when a professional liability claim is received is whether to defend or aggressively attempt to settle the case. The Illinois State Medical Inter-Insurance Exchange (ISMIE) has always vigorously defended claims and suits without merit to deter future frivolous claims. But, many medical and non-medical factors affecting medical malpractice must be carefully weighed and considered when making the defend or settle decision.

ISMIE continues to involve insured physicians in the decision to settle or defend a claim. A physician review committee, a group of physicians, meets to evaluate claims and make recommendations regarding settlement or defense, with the input and cooperation of the insured physician.

Sometimes physician defendants have trouble separating their emotions from the decision to settle or defend. This may lead to insisting on defending a hopeless claim or insisting on settling a defensible claim, for reasons ranging from simple fear to not wanting to take the time to deal with the situation.



Fred Z. White, M.D.

In some cases, a physician will make an objective decision regarding settlement/defense only to panic later and reverse it. This usually happens when a trial date is set for the lawsuit. This makes appropriate and timely handling of the claim difficult, and can be interpreted by the insurer as failure to cooperate with the investigation and defense of the claim, a responsibility as an insured.

In order to help separate emotions from objective facts, the following is a list of factors which commonly impact the defensibility of a malpractice claim. Evaluation of each of these factors as they apply to a claim will help to direct a more objective assessment of the defensibility of the claim. These are the factors commonly used to evaluate malpractice claims.

Factors affecting defend/settle decisions

1. Professional liability analyst's evaluation

A professional liability analyst experienced in the investigation and handling of medical malpractice claims will promptly conduct an initial investigation to obtain objective facts regarding the merits of the claim, and positive and negative defense factors to report to the physician review committee. The complexity of the case will be a factor in determining how long it takes to complete the initial investigation. It can take a few weeks or a few months. Records of other physicians or hospitals may have to be subpoenaed in order to evaluate any injury claimed by the plaintiff. This and any other delays in collecting necessary information will affect the length of the process.

The professional liability analyst will coordinate the claim through all stages of the investigation and defense, working with the insured defendant and the defense attorney. Any material facts discovered that may alter the defend/settle decision are reported to the physician review committee for further consideration.

2. Medical evaluation of medical records

One or more physicians with adequate training and experience in appropriate medical specialties will review the records and report a medical opinion on the "standard of care" provided to the patient. This will be used to determine if actual or probable negligence could be present in the care and treatment of the patient. This is done as soon as the professional liability analyst has obtained the necessary medical records for the physician review.

ISMIE uses consultants who are practicing Illinois physicians in all medical specialties to provide the initial review of the claim. All other specialists who may be required to provide expert witness testimony will be identified with the assistance of the insured physician, and provided if defense of the claim is recommended. Other medical consultants will also be obtained for the initial review of the claim if indicated.

3. Defensibility of medical records

The availability of accurate and complete medical records is essential for the defense of a medical malpractice claim. Too often, inadequate or inappropriate documentation must be a key reason for recommending settlement of a claim which, from a medical standpoint, may have been defensible.

4. Serious documentation errors, omissions or alterations

The presence of serious errors or omissions in documentation will impact negatively on the defense of any malpractice claim. Alterations of records or missing records will automatically destroy most chances to defend the claim.

It is imperative that the defense team be notified immediately if any of these documentation problems exist. If discovered later by the plaintiff's attorney, the effect will be devastating and the defense team will be left unprepared to deal with the damage to the defense.

5. Sympathy factors

A malpractice case is tried in front of a jury of 12 of the plaintiff's peers, so sympathy factors that would sway the jury further to the plaintiff's side must be weighed in determining defensibility of the claim. The plaintiff's age, appearance and extent of injury are considered as each case is evaluated on its individual merits.

6. Locality trends

Illinois is divided into three territories based on the frequency and severity of liability claims. The chances of successfully defending a claim may vary with the territory as will the potential severity of an adverse outcome. The awards the local courts have set down in similar cases will be considered in evaluating defensibility of the claim.

An example would be a situation where a recent excessive verdict was handed down by the local court for a similar case, with no apparent rational reason for the verdict. Appearing before the same court with a like situation may be avoided if the opportunity for a reasonable settlement exists. The same case may have been defended under other circumstances, but in this particular instance, one or more factors indicate settlement as the best course.

7. Credibility of witnesses including the defendant and plaintiff

The testimony of witnesses is used to establish defense and to convince a jury that there was no malpractice involved on the part of the defendant. The credibility of witnesses, including the defendant and the plaintiff, can sway the outcome of a trial regardless of objective facts. A

(continued on page 7)

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physician defendant who appears arrogant and impatient to the jury will not be able to gain its support. The jury will be more likely to believe the plaintiff's story.

The total case against the health-care team must be reviewed. For example, key testimony may revolve around a time period where a specific nurse was in charge of the patient's care. That nurse's ability to appear competent and confident in front of the jury will favor defense. If the nurse is so nervous that testimony will be unpredictable under the pressure of cross-examination, this can negatively impact defense for all defendants.

This is a very difficult area for the insured physician to evaluate objectively. Therefore, reliance on the defense team's opinion and advice is required. Some negative credibility factors can be changed if the physician is open to listening to and actively following the advice of the team.

Sometimes physician defendants have trouble separating their emotions from the decision to settle or defend.

In spite of efforts by the defense team to prepare witnesses completely to deal with the stress of a jury trial, some behavior and appearance factors cannot be changed, so the impact on the jury must be considered.

The time required for a case to reach trial may result in a defendant not being available due to death or disability. If the physician defendant is not available to speak on his/her own behalf, this can be a negative factor in defense. An example would be the death of the defendant physician prior to a trial involving a very "sympathetic" plaintiff. Avoidance of a complicated trial without the defendant available to speak in his/her own behalf may be recommended, where defense would have been recommended under other circumstances.

8. Anticipated finger-pointing among defendants

In cases in which one or more of the defendants is trying to shift blame away by directing it toward other defendants, the plaintiff will get free assistance in establishing a case for negligence, even when it does not exist. It is hoped that a cooperative relationship among defendants can be worked out, but if finger-pointing does exist, it will impact negatively on the ability to defend the case. ▲

See the next Illinois Medicine *for the concluding installment of "Defend or Settle"*

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References: 1. Lund-Johansen P: Hemodynamic changes at rest and during exercise in long-term prazosin therapy for essential hypertension, in *Prazosin Clinical Symposium Proceedings*. Published as a special report by *Postgraduate Medicine*. New York, McGraw-Hill Co, 1975, pp 45-52 **2.** Komajda M: Prazosin and lipids: A study of the effects of prazosin on blood lipids in hypertensive patients. *Impact Int* December 1986; (special issue): 1-4 **3.** Rouffy J, Jaillard J: Effects of two antihypertensive agents on lipids, lipoproteins, and apoproteins A and B: Comparison of prazosin and atenolol. *Am J Med* 1986;80(suppl 2A):100-103 **4.** Lowenstein J, Neusy A-J: Effects of prazosin and propranolol on serum lipids in patients with essential hypertension. *Am J Med* 1984; 76(2A):79-84 **5.** Stamler R, Stamler J, Gosch FC, et al: Initial antihypertensive drug therapy: A comparison of alpha blocker (prazosin) and diuretic (hydrochlorothiazide): Final report of a randomized, controlled trial. In press. **6.** Leren P, Helgeland A, Holme I, et al: Effect of propranolol and prazosin on blood lipids: The Oslo Study. *Lancet* 1980, II:4-6. **7.** Kwan CM, Shepherd AMM, Johnson J, et al: Forearm and finger hemodynamics, blood pressure control and lipid changes in patients with diabetic hypertension treated with atenolol and prazosin. *Clin Pharmacol Ther* 1988;44:202-209 **8.** Leichter SB, Baumgardner R: Effects of chronic prazosin therapy on intermediary metabolism in diabetic patients. *J Cardiovasc Med* 1981;(special suppl):38-42.

Brief Summary
MINIPRESS (prazosin hydrochloride) CAPSULES ***For Oral Use***
INDICATIONS AND USAGE: MINIPRESS (prazosin hydrochloride) is indicated in the treatment of hypertension. It is mild to moderate in activity and can be used as the initial agent or in a general treatment program in conjunction with a diuretic and/or other antihypertensive drugs as needed. **CONTRAINDICATIONS:** None known. **WARNINGS: MINIPRESS may cause syncope with sudden loss of consciousness. In most cases this is believed to be due to an excessive postural hypotensive effect, although occasionally the syncopal episode has been preceded by a bout of severe tachycardia with heart rates of 120–160 beats per minute. Syncopal episodes have usually occurred within 30 to 90 minutes of the initial dose of the drug; occasionally they have been reported in association with rapid dosage increases or the introduction of another antihypertensive drug into the regimen of a patient taking high doses of MINIPRESS. The incidence of syncopal episodes is approximately 1% in patients given an initial dose of 2 mg or greater. Clinical trials conducted during the investigational phase of this drug suggest that syncopal episodes can be minimized by limiting the initial dose of the drug to 1 mg, by subsequently increasing the dosage slowly, and by introducing any additional antihypertensive drugs into the patient's regimen with caution (see DOSAGE AND ADMINISTRATION). Hypotension may develop in patients given MINIPRESS who are also receiving a beta-blocker such as propranolol.** If syncope occurs, the patient should be placed in the recumbent position and treated supportively as necessary. This adverse effect is self-limiting and in most cases does not recur after the initial period of therapy or during subsequent dose titration. The patient should also be cautioned to avoid situations where injury could result should syncope occur during the initiation of MINIPRESS therapy. **PRECAUTIONS:** ***Information for Patients:*** Dizziness or drowsiness may occur after the first dose of this medicine. Avoid driving or performing hazardous tasks for the first 24 hours after taking this medicine or when the dose is increased. Dizziness, lightheadedness or fainting may occur, especially when rising from a lying or sitting position. Getting up slowly may help lessen the problem. These effects may also occur if you drink alcohol, stand for long periods of time, exercise, or if the weather is hot. While taking MINIPRESS, be careful in the amount of alcohol you drink. Also, use extra care during exercise or hot weather, or if standing for long periods. Check with your physician if you have any questions. ***Drug Interactions:*** MINIPRESS has been administered without any adverse drug interaction in limited clinical experience to date with the following: (1) cardiac glycosides–digitalis and digoxin, (2) hypoglycemics–insulin, chlorpropamide, phenformin, tolazamide, and tolbutamide, (3) tranquilizers and sedatives–chlordiazepoxide, diazepam, and phenobarbital; (4) antigout–allopurinol, colchicine, and probenecid; (5) antiarrhythmics–procainamide, propranolol (see WARNINGS however), and quinidine, and (6) analgesics, antipyretics and anti-inflammatories–propoxyphene, aspirin, indomethacin, and phenylbutazone. Addition of a diuretic or other antihypertensive agent to MINIPRESS has been shown to cause an additive hypotensive effect. ***Drug/Laboratory Test Interactions:*** False positive results may occur in screening tests for pheochromocytoma in patients who are being treated with prazosin. If an elevated VMA is found, prazosin should be discontinued and the patient retested after a month. ***Laboratory Tests:*** In clinical studies in which lipid profiles were followed, there were generally no adverse changes noted between pre- and post-treatment lipid levels. ***Carcinogenesis, Mutagenesis, Impairment of Fertility:*** No carcinogenic potential was demonstrated in an 18 month study in rats with MINIPRESS (prazosin hydrochloride) at dose levels more than 225 times the usual maximum recommended human dose of 20 mg per day. MINIPRESS was not mutagenic in *in vivo* genetic toxicology studies. In a fertility and general reproductive performance study in rats, both males and females, treated with 75 mg/kg (225 times the usual maximum recommended human dose), demonstrated decreased fertility while those treated with 25 mg/kg (75 times the usual maximum recommended human dose) did not. In chronic studies (one year or more) of MINIPRESS in rats and dogs, testicular changes consisting of atrophy and necrosis occurred at 25 mg/kg/day (75 times the usual maximum recommended human dose). No testicular changes were seen in rats or dogs at 10 mg/kg/day (30 times the usual maximum recommended human dose). In view of the testicular changes observed in animals, 105 patients on long term MINIPRESS therapy were monitored for 17-ketosteroid excretion and no changes indicating a drug effect were observed. In addition, 27 males on MINIPRESS for up to 51 months did not have changes in sperm morphology suggestive of drug effect. ***Usage In Pregnancy:*** Pregnancy Category C: There are no adequate and well controlled studies which establish the safety of MINIPRESS (prazosin HCl) in pregnant women. MINIPRESS should be used during pregnancy only if the potential benefit justifies the potential risk to the mother and fetus. ***Nursing Mothers:*** MINIPRESS has been shown to be excreted in small amounts in human milk. Caution should be exercised when MINIPRESS is administered to a nursing woman. ***Usage in Children:*** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS:** Clinical trials were conducted on more than 900 patients. During these trials and subsequent marketing experience, the most frequent reactions associated with MINIPRESS therapy are: dizziness 10.3%, headache 7.8%, drowsiness 7.6%, lack of energy 6.9%, weakness 6.5%, palpitations 5.3%, and nausea 4.9%. In most instances side effects have disappeared with continued therapy or have been tolerated with no decrease in dose of drug. Less frequent adverse reactions which are reported to occur in 1–4% of patients are: *Gastrointestinal:* vomiting, diarrhea, constipation, *Cardiovascular:* edema, orthostatic hypotension, dyspnea, syncope; *Central Nervous System:* vertigo, depression, nervousness; *Dermatologic:* rash; *Genitourinary:* urinary frequency; *EENT:* blurred vision, reddened sclera, epistaxis, dry mouth, nasal congestion. In addition, fewer than 1% of patients have reported the following (in some instances, exact causal relationships have not been established): *Gastrointestinal:* abdominal discomfort and/or pain, liver function abnormalities, pancreatitis; *Cardiovascular:* tachycardia; *Central Nervous System:* paresthesia, hallucinations; *Dermatologic:* pruritus, alopecia, lichen planus; *Genitourinary:* incontinence, impotence, priapism; *EENT:* tinnitus; *Other:* diaphoresis, fever. Single reports of pigmentary mottling and serous retinopathy, and a few reports of cataract development or disappearance have been reported. **OVERDOSAGE:** Should overdosage lead to hypotension, support of the cardiovascular system is of first importance. Restoration of blood pressure and normalization of heart rate may be accomplished by keeping the patient in the supine position. If this measure is inadequate, shock should first be treated with volume expanders. If necessary, vasopressors should then be used. Renal function should be monitored and supported as needed. Laboratory data indicate MINIPRESS is not dialysable because it is protein bound. **DOSAGE AND ADMINISTRATION:** The dose of MINIPRESS should be adjusted according to individual blood pressure response. ***Initial Dose:*** 1 mg two or three times a day. ***Maintenance Dose:*** Dosage may be slowly increased to a total daily dose of 20 mg given in divided doses. The therapeutic dosages most commonly employed have ranged from 6 mg to 15 mg daily given in divided doses. Doses higher than 20 mg usually do not increase efficacy; however a few patients may benefit from further increases up to a daily dose of 40 mg given in divided doses. After initial titration some patients can be maintained adequately on a twice daily dosage regimen. ***Use With Other Drugs:*** When adding a diuretic or other antihypertensive agent, the dose of MINIPRESS should be reduced to 1 mg or 2 mg three times a day and retitration then carried out.
Revised December 1988

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ISMS physician assistance program helps medical families regain satisfying lives

Healing the healer

by Janice Rosenberg

HELPING impaired physicians enter treatment and return to effective medical practice is the number one goal of the Illinois State Medical Society's (ISMS) physician assistance program. James West, M.D. initiated a group of volunteer physicians in 1973 to aid the impaired physician. Today, the program, run under the auspices of the Society's physician assistance committee, has a full time medical director and provides advocacy, monitoring and guidance for over 100 physicians.

Violet M. Eggert, M.D., medical director of the physician assistance program, said, "Most people think our program deals solely with physicians impaired by drug and alcohol dependency, but we also deal with psychiatric disabilities, dual diagnoses, physical impairment, problems of aging, sexual misconduct, and the distress of every day medical practice."

Troubled physicians, their colleagues or families can reach Dr. Eggert directly on the ISMS twenty-four hour "Physician Help Line," 312-580-2499. "There's a greater acceptance of help by the suffering physician if he or she knows they are dealing with other physicians," she said. Dr. Eggert is herself a recovering physician, a fact she willingly admits to nervous, frightened colleagues who come to her for help. "It gives them the feeling that I'm not judgmental. I can empathize with them."

While some physicians come to the program on their own, others are reported or referred to Dr. Eggert or the program by a peer. The program investigates the allegations of impairment, as Dr. Eggert said, "very quietly, very unobtrusively. We get all the data together—days, times, exactly what the occurrences are—and we present it to the physician. If the physician is unwilling to accept treatment, we intervene."

An intervention is a caring confrontation between the impaired physician, an intervention leader such as Dr. Eggert, and those individuals who have personal knowledge of the physician's problems. The program has trained volunteer physician intervenors throughout the state. Dr. Eggert has found that peer group interventions work far better than one-on-one confrontations. "Those," she said, "most often end up as two people hollering at each other."

The interventions are designed to motivate the physician into treatment. When an intervention does not result in the physician's cooperation, a second intervention can be organized. "We don't forget about them, and we don't give up," said Dr. Eggert. "Occasionally the person has to be faced with discipline from a hospital or state agency before they will accept care. However," she emphasized, "the program has no power to take away a physician's license. In fact, we have no disciplinary powers whatsoever. We wish to rehabilitate and return physicians to practice."

Pressure, when it is applied, comes from the physician's hospital board in the form of limited or lost privileges. In cases where patients may be harmed or the physician is unwilling to accept treatment, the Illinois Department of Professional Regulation may use its' power to suspend or revoke medical licenses.

Success of programs

According to Dr. Eggert, most interventions are successful. The disabled physician then signs a contract with the ISMS physician assistance program agreeing to an individualized course of treatment. He or she further agrees to participate in appropriate self-help groups. The program monitors attendance at support groups and treatment. Also, physicians who have had substance abuse problems are monitored by random toxicology for three to five years after completing treatment.

Treatment centers may be recommended by the program. "We have certain treatment programs that we know have a good track record in treating physicians effectively. Studies have shown physicians who complete treatment have an over 80 percent recovery rate at the end of five years," said Dr. Eggert.

Interventions occur only when there is concrete evidence of behavior indicating the physician has a problem. While the last place an impairment is observed is in the hospital or physician's office, friends and family members are often first aware of problems. State law provides immunity protection for people who report the impaired physician to the physician assistance program, as well as protection for those who participate in interventions. All such information is barred from discovery or subpoena by the Medical Studies Act.

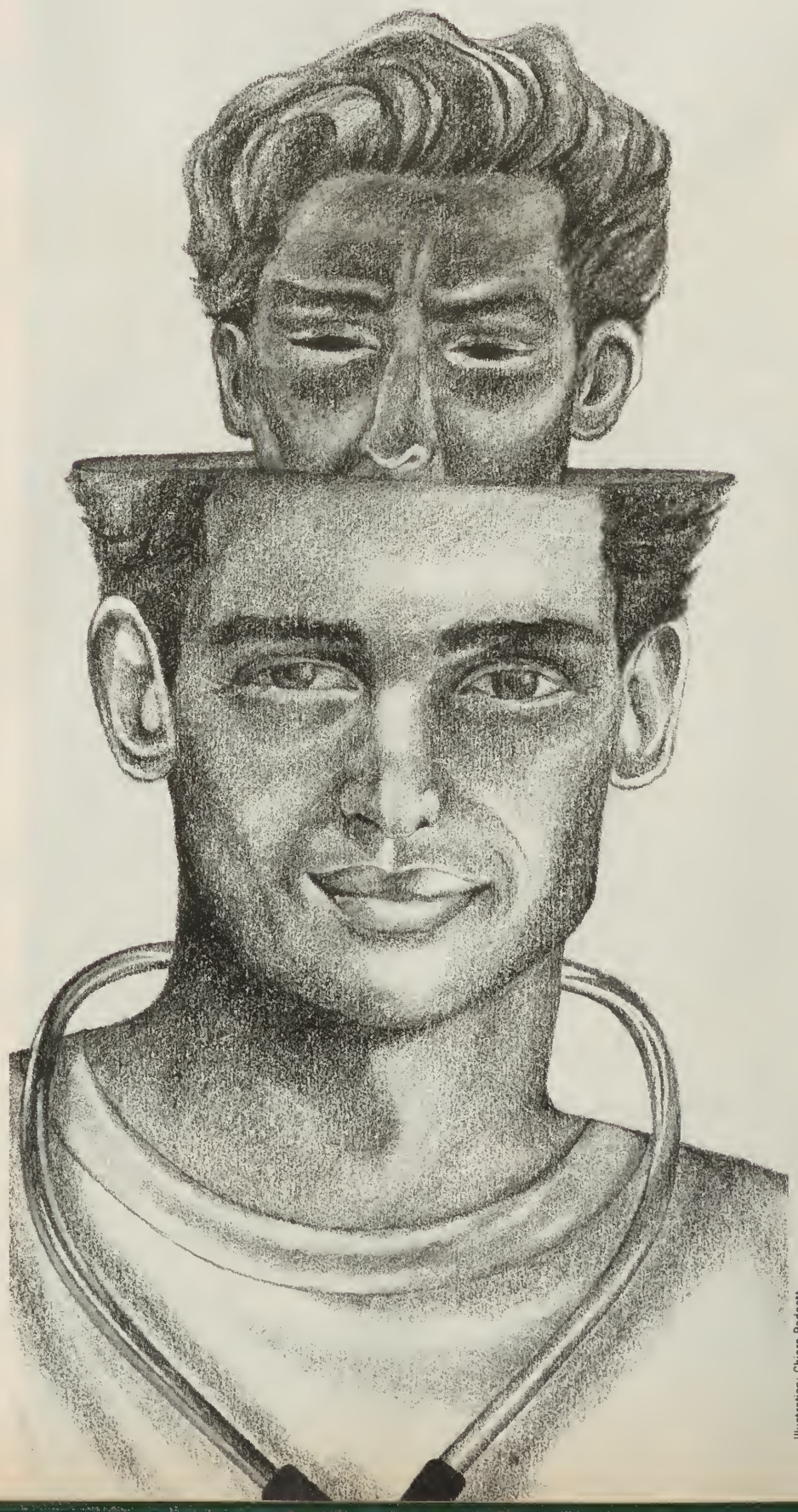


Illustration: Chiara Padgett

The medical family program

The ISMS physician assistance program is currently organizing the new medical family program.

"The physician assistance committee sees the program as an aid to the medical family," said Dr. Eggert. "To me, that means anyone in the physician's immediate or extended family—a daughter, son, brother, mother, father, spouse, or close friend who is concerned about the physician, can benefit from our program." The concerned individual may find that his or her own life is in shambles due to over-involvement in the impaired physician's problems. "We want to help people save their own lives and at the same time eventually have them motivate the physician to accept treatment." Conversely, a physician's practice may be affected by the chemical dependency of a spouse, parent, son or daughter. These physicians would also benefit from the medical family program.

The program will consist of weekly group meetings where concerned individuals can get together and talk about their problems. A professional facilitator will work with the group.

Often those concerned about an impaired physician fear that by seeking help they will cause trouble for the physician. They fear revealing the name of the physician will destroy his or her practice or incur legal repercussions. Kathy Angres, M.S., Illinois State Medical Society Auxiliary representative to the physician assistance committee and a group facilitator, stated emphatically that the medical family program will be strictly confidential.

"The physician himself does not have to be in treatment for a concerned party to come to our group sessions," said Angres. "The medical family program will offer peer group environment where people can go to talk and get out some honest gut feelings."

Dr. Eggert plans to have the program underway Thursday, September 14, from 8 p.m. to 9:30 p.m. at the Christ Church of OakBrook, 31st and York, in OakBrook. Participants are invited to attend any Thursday evening, or call Dr. Eggert at the Help Line, 312-580-2499. This pilot program will be expanded throughout the state within one to two years.

While Dr. Eggert calls herself "a treatment person," Michael Newman, M.D., immediate past chairman of the physician assistance committee and medical director of obstetrical anesthesia at Rush Presbyterian St. Luke's Medical Center, approaches physician impairment from the prevention side. Dr. Newman sees stress as a leading cause of drug dependency problems. "I can't *prove* that if people manage stress better they're going to have a reduction in impairment," he said, "but I think it's so. We're looking at management programs as ways of giving people coping skills."

Dr. Newman emphasizes stress

management rather than stress reduction. "People think, 'Maybe if I can change something out there I won't be stressed,'" he said. "But I think you've got to change something inside. Whatever is out there will still be out there, but you won't be stressed."

Debra Klamen, M.D., a teaching staff member in psychiatry at the University of Illinois and resident representative to the physician assistance committee, runs stress reduction workshops for residents. She covers the definition of stress and burn out, the use of social supports as buffers against stress, self-care and relaxation skills, assertiveness training, communication skills, and self-management options under stress. "Some physician impairment can't be prevented with stress reduction," she said. "But at least the threshold for impairment can be raised."

"We're about as good as we're going to get at detecting and treating chemical dependency," said Dr. Newman. "What we absolutely have to have are more programs like Dr. Klamen's."

A personal reason for involvement and commitment

Another member of the physician assistance committee, Thomas J. Krizek, M.D., professor and chairman of the department of surgery at the University of Chicago Medical School and the University of Chicago Medical Center, has a personal reason for his involvement with impaired physicians. He is a recovering alcoholic. Dr. Krizek stopped drinking ten years ago. "I absolutely believe that alcoholism is a disease," he said. "When I had a drink something triggered me that does not trigger other people. And after two or three drinks, the desire to drink was overwhelming."

Studies have shown physicians who complete treatment have an over 80 percent recovery rate at the end of five years.

Despite his drinking, Dr. Krizek served as a professor at Yale and Columbia University Medical Schools. "As I advanced in my medical career, I became more protected from patients' calls. I created a situation in which residents and junior faculty enabled my drinking. The residents didn't call me at night. They knew what was going on."

Today, Dr. Krizek lectures medical students on physician impairment. He tells them how they can best help their colleagues. "Don't confront the person," he advises. "Call me. I know how to handle it. Or call the ISMS physician assistance program. They've worked out the mechanism for handling this kind of thing."

In his own recovery, Dr. Krizek did not undergo an intervention, nor was he ever hospitalized. "I think my recovery would have started a lot sooner if some group had intervened or if I had been hospitalized," he said. Instead, with some help from a psychiatrist and with his wife as a guide, he made his own way out of impairment. "I used to give up drinking for Lent and that proved I wasn't an alcoholic," he said. "But really it didn't prove that at all. To wake up one morning and say 'I'm not going to drink again,' well, I'd done that hundreds of times. But this time I didn't drink again."

When he quit drinking Dr. Krizek took up jogging. "You have to go through behavior modification," he said. "When I came home, instead of making a shaker of martinis, I put on my running clothes."

Dr. Krizek cites his own case as proof that physicians who are substance abusers can rise to the top of the profession. He sees it also as indicating that impaired physicians can sometimes recover without intervention, hospitalization, or specialized care. "But," he said, "I'm convinced that the most dependable and best way out of it is early intervention and treatment." ▲

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Brief Summary

Consult the package literature for complete information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* — 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests — False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions — No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility — A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice; although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy — Teratogenic Effects — Pregnancy Category C — Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers — Studies conducted in lactating women have shown that <0.1% of the administered oral dose of nizatidine is secreted in human milk in proportion to plasma concentrations. Caution should be exercised when administering nizatidine to a nursing mother.

Pediatric Use — Safety and effectiveness in children have not been established.

Use in Elderly Patients — Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among reported adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs < 0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic — Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients and was possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L) and, in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular — In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS — Rare cases of reversible mental confusion have been reported.

Endocrine — Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic — Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental — Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity — As with other H_2-receptor antagonists, rare cases of anaphylaxis following administration of nizatidine have been reported. Because cross-sensitivity in this class of compounds has been observed, H_2-receptor antagonists should not be administered to individuals with a history of previous hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other — Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine administration have been reported.

Overdosage: Overdoses of Axid have been reported rarely. The following is provided to serve as a guide should such an overdose be encountered.

Signs and Symptoms — There is little clinical experience with overdosage of Axid in humans. Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous median lethal doses in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

Treatment — To obtain up-to-date information about the treatment of overdose, a good resource is your certified regional Poison Control Center. Telephone numbers of certified poison control centers are listed in the *Physicians' Desk Reference (PDR)*. In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient.

If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance.

PV 2096 AMP [013089]

Additional information available to the profession on request.

(continued from page 3)

the group congregated on the sidewalk, and turn away. "See, some of them are intimidated," says Doyle. "All we do is approach them and ask if they'd like some literature."

Doyle arms herself with literature containing graphic photographs of fetuses, as well as detailed descriptions of fetal development and the Crisis Pregnancy Hotline phone number, where phones are staffed by pro-life members. The picketers carry signs that range from slogans like "As a former fetus, I oppose abortion," to photographs. "This [photo] is of an 8-week old fetus," says Doyle. "That's what you'd see if you put it under a microscope. Most of the girls going in [NIWC] are at least 8½ weeks pregnant." According to Traynor, NIWC only performs abortions in the first trimester of pregnancy.

NIWC's large parking lot is fenced in and has only one entrance gate. Three yellow, parked school buses block the view past the front section of the fence, in an effort to preserve patient anonymity. Rock music blares from an outdoor intercom. "The music drowns out shouts of Bible verses and verbal abuse from the picketers," Traynor explains. "This choice has been tough enough on these women. They don't need added aggravation. The video camera [at the entrance gate] keeps protestors out and also helps when they make unsubstantiated charges of battery against us."

The video camera was installed by building owner Gerald (Wayne) Webster.

Last April 28, during a pro-life "sit-in" at the clinic, a group of about 35 removed the clinic's front door (which is always locked) from its hinges to gain entry. Webster stepped into their way. A dozen protestors were arrested for battery. Webster sustained a sprained wrist and dislocated finger, and a retired part-time custodian at the clinic also suffered minor injuries.

According to Webster, the group has also cut the tires on his car. Helen Doyle admits the group once placed broken glass in front of Webster's tires "in a heated moment. But we changed our minds and swept it away."

"Rockford may prove important in the [national] debate because of Dr. Ragsdale's pending Supreme Court case," says Dr. Norem. "If they uphold the regulations, it'll put him out of business, and no surgicenter is about to start performing abortions."

Raymond Hoffmann, M.D., a Rockford trauma surgeon and vice speaker of the ISMS House of Delegates commented, "There's little financial stimulus in it for [Ragsdale]. If he were a member of a large clinic and had the support of all his colleagues, it would seem a whole lot different. But when you see all the heat he's taken over the years, it's apparent that it's part of the territory he's accepted in order to keep his clinic here." ▲

Rockford physician heads toward the U.S. Supreme Court on abortion

Richard Ragsdale, M.D., a Rockford physician, is in the media spotlight, following the U.S. Supreme Court decision to hear his case, *Turnock* v. *Ragsdale*, this fall. The ruling could have a significant impact on outpatient facilities which provide abortion services. According to Colleen Connell, his attorney at the American Civil Liberties Union, Dr. Ragsdale in 1985 challenged three Illinois statutes at issue in the case, after his lease in a medical arts building was not renewed and he was unable to find a facility in Rockford that the state would license to perform abortions.

In a prepared statement to *Illinois Medicine* on the abortion debate and his upcoming U.S. Supreme Court hearing, Dr. Ragsdale said that the three laws, including the Ambulatory Surgical Treatment Center Act, a section of the Medical Practice Act and the certificate of need provision in the Health Facilities Planning Act's work together to form an integrated statutory scheme that makes it nearly impossible for physicians who want to perform early abortions to rent or construct a facility that complies with this burdensome law. "The regulations interfere with and impede a physician's exercise of professional judgment," Dr. Ragsdale said. "For example, some of the regulations require mandatory counseling, even when the specifics of the counseling would be inappropriate given the medical condition of the woman."

He continued, "Other regulations would not allow a physician who advises a woman considering abortion for [a] medical condition such as fibroids to perform the procedure. Moreover, the regulations are medically unnecessary, do nothing to improve the safety of an early abortion, which is the safest surgical procedure performed in this country, and do not result in any improvement of the health care of women," Dr. Ragsdale said.

Dr. Ragsdale's prepared statement said that "both the lower federal courts who reviewed the case concluded that the challenged Illinois statutes, [which are] modeled in many respects upon the Hospital Licensing Act, unconstitutionally require a physician who wants to provide abortion services to construct a clinic that is the functional equivalent of a tertiary care hospital. These lower courts found that this elaborate statutory scheme does nothing but inflate the already high cost of health care."

Dr. Ragsdale noted in his statement that the lower courts also found that this statutory scheme was intended to, and did in fact, make abortions more difficult and expensive to obtain. The statement said, "Outside of Chicago, abortion facilities [are] not widely available. . . . Even in Chicago, many reputable clinics operated by physicians of integrity had trouble complying with this arbitrary and unnecessary regulatory scheme." ▲

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PANS

(continued from page 2)

He said his four member group severed its relationship with PANS last October, making a settlement with the IPA at that time for some of the fees owed. He said the exception to this was that the group would continue to treat pregnant patients who were already being treated at the time of the settlement. He said as part of the settlement, the group wrote off a substantial amount of the fees that were owed. Even with that, he said, PANS owes the group money in the range of "six figures plus . . . way plus" and he has no hope of seeing that money. The fees still outstanding are a result of the group's continuing to treat the pregnant women after the October settlement, he said.

"I think what happened is you have a conflict between advertised benefits, patient expectations and the reality of what the system is able to afford. Now you hear all over television and radio how wonderful HMOs are and you can see your doctor whenever you want for whatever you want. On the other hand the third party payers are taking 20 to 30 per cent off the top for their profit and operating expense, dividing up what's left among the providers and expecting the patients to be able to get frequent access to high quality service. The mathematics just don't work out," said Dr. Wagner.

Like Dr Grebelny, Dr. Wagner said demographics played a role in the problems experienced by PANS.

"The Chicago north shore is a sophisticated, high utilization market. Patients are used to seeing their doctor annually. They're used to being able to have rapid access to high tech services. They're used to a high level of care utilization. The name of the game in HMOs is 'control the access' and that's not what the market we serve is interested in," said Dr. Wagner.

He said that from the patient's point of view the HMO is "a wonderful thing" and from the employer's point of view it's "a great idea. The health care dollar is off their back."

"The burden and risk have been shifted substantially from the insurance company which is, by nature and intent, the actuarily-based, risk-taking organization, to a group of physicians who, by experience and training, are not risk takers. They're interested in providing care," said Dr. Wagner. "If I have a vested interest in not delivering care, which I do as a member of an HMO, it really sets up some serious conflicts," he added.

Dr. Wagner said since he was not a primary care physician, he did not receive a capitated rate. "The best we ever did with PANS was 60 per cent of our usual and customary rate . . . when we got paid."

Asked if he had words of wisdom for physicians who might be contemplating IPA involvement, Dr. Wagner had some brief advice: "Don't." ▲

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

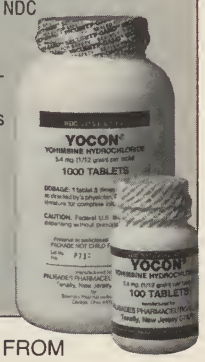
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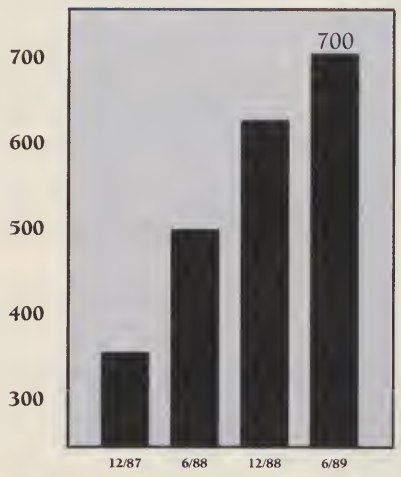


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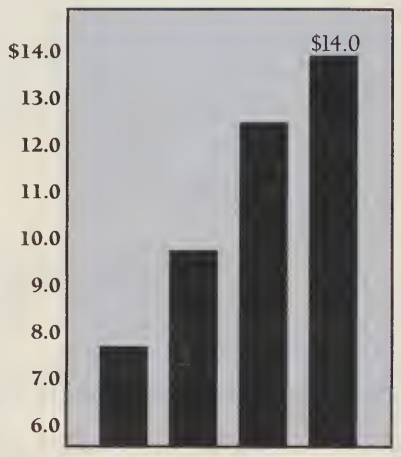
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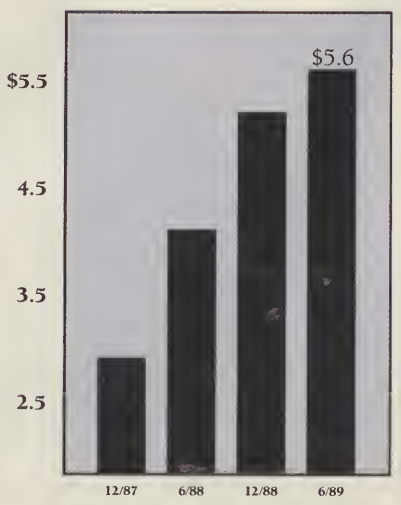
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(continued from page 1)

their [need for] hospitalization."

Since then, PRO activities have grown in leaps and bounds, the most recent being administration of preadmission certification requirements for ten new elective Medicare procedures. But the PRO's major mission has remained unchanged: "to monitor the care beneficiaries receive, primarily in acute settings," says Thomas Hyngstrom, Ph.D., CCFMC executive director. He adds that, within that setting the PRO has two major charges, "We look at the appropriateness of utilization and the quality of care received."

CCFMC is under contract with the federal government—specifically the Health Care Finance Administration (HCFA)—to monitor and enforce compliance statewide with Medicare's rules. Outside of the Chicago metropolitan area, CCFMC subcontracts with the Central Illinois Medical Review Organization to perform PRO activities.

Dr. Hyngstrom stresses "the bottom line is the government holds us [CCFMC] responsible for the entire contract and communicates only with us."

"Our current contract ends in September of this year," he adds. CCFMC has received a three year contract extension after responding to a noncompetitive request for proposal from HCFA. While the federal government appears satisfied to continue CCFMC's contract, it has pushed this—and all—PROs nationwide to be more aggressive.

Examining the record

Dr. Hyngstrom believes Illinois doctors should be pleased with CCFMC as a moderate, evenhanded review organization. As opposed to being solely an oversight agency, the PRO sees itself as physician-directed—with responsibilities to the medical community as well as seniors. "You cannot name any review activity we're in that is not required by law," he claims. "Conversely, we offer more safeguards to hospitals and physicians than are in the law or paid for by HCFA."

Joseph Daw, M.D., an internal medicine specialist from Oswego, chairs the PRO's 25 member board of directors. He joined CCFMC's board in 1980, at the request of the Kane County Medical Society.

Comprised of Illinois physicians, hospital administrators and a consumer representative, the board sets the tone for the PRO's operation. "We have one of the most comprehensive [review] processes of any PRO, to make sure that physicians' rights are safeguarded along the way," says Dr. Daw.

Donald Rokosch, M.D., chairman of the ISMS Council on Economics, agrees the PRO board is "trying hard to implement an unfair program in as fair a manner as HCFA will allow," a statement Dr. Daw characterizes as "fair." Adds Dr. Rokosch, "Sometimes they succeed better than others."

In most instances, problems are largely due to implementing HCFA directives, according to Dr. Kiessel. He cites "some nonsensical letters that went out under previous HCFA rules. There was a lot of controversy about some of the things for which letters were sent, because of federal standards or suggestion."

Dr. Hyngstrom stresses CCFMC has worked closely with Illinois' medical community, including ISMS and the Illinois Hospital Association, to identify and solve problems such as these. The various screens and physician reviewers CCFMC uses to look at both utilization and quality issues are "meant to assure that we don't have frivolous issues," he says.

CCFMC uses medical records to make judgments. If important facts are missing from the record, it can and often does trip up the PRO's ability to make accurate assessments about quality and reasonableness of care.

For instance, by the time CCFMC contacts a doctor to express concern about quality of care for an individual Medicare patient, a panel of

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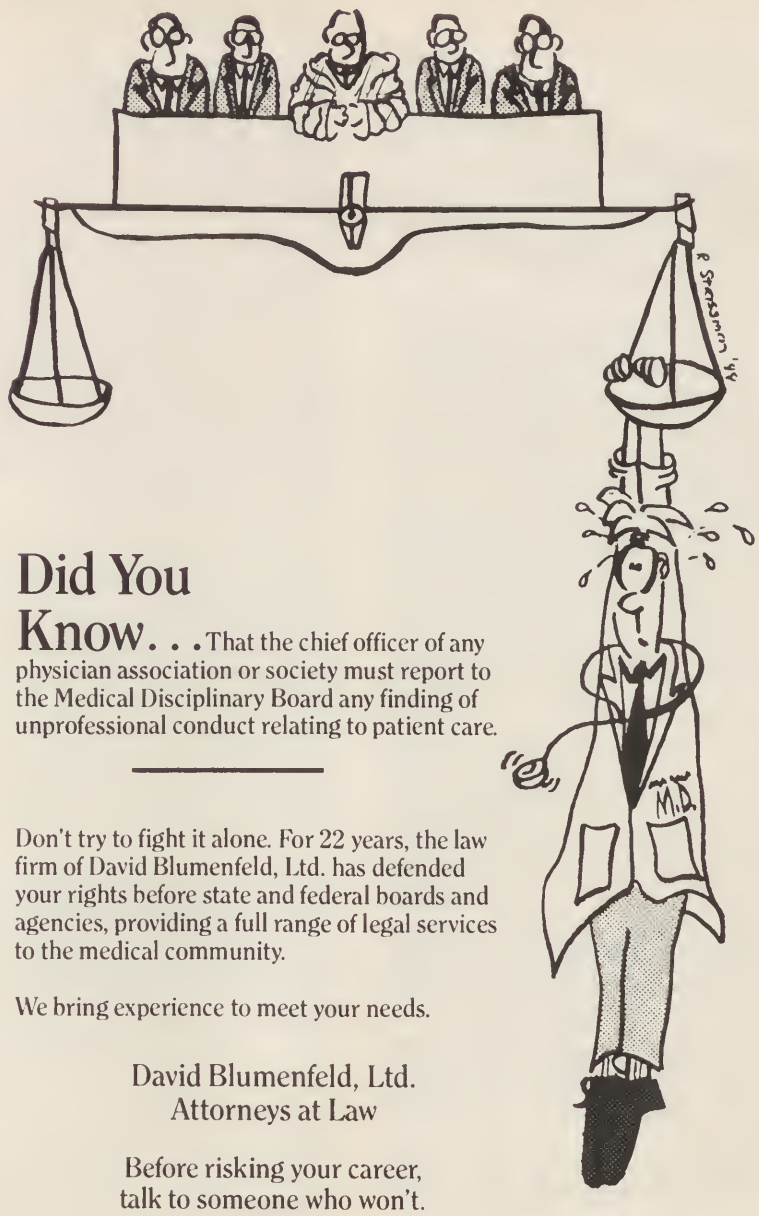
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physician reviewers has already checked out the case to make sure "we don't have a frivolous issue," says Dr. Hyngstrom. Despite that, "about two thirds of the time, a case is reversed after input from the [attending] doctor. He can respond right there, when he gets that first inquiry."

Still, about 40 percent of physicians receiving letters do not respond to the PRO's initial contact. Failure to do so almost always leads to more hassle in the end. "The case progresses to the next level of review, which only complicates matters," says Dr. Hyngstrom. "When the doctor finally does respond, he claims 'Your system is flawed because it got all the way up here and was a silly issue.' When that happens, it's invariably because the medical records are incomplete, not because our reviewers are incompetent."

Dr. Kiessel agrees "there are some problems with completeness of records" the PRO has been able to demonstrate. But when questions seem silly, it tries the patience of doctors, who give up trying to respond."When you get eight letters a week from the PRO and four are nonsense, you'll be dictating in the medical records room for four to six hours explaining something that doesn't need it. It's easy for the PRO to say all we have to do is answer the letter."

Dr. Daw concedes that one of the PRO's biggest problems has been that "sometimes questions are raised in specific cases that don't need to be brought up. These seem to be very minor technicalities to the practicing physician, yet we are required to do [them by the Medicare program.]"

A modification in the PRO's new contract with the federal government allows it more leeway. "We don't have to contact physicians for minor technical issues unless there's an accumulation of three in a three month period or five in a five month period," explains Dr. Daw.

Of course, major substantive disagreements about medical care also occur. CCFMC's elaborate, multi-layered review process is intended to thrash out those issues. As might be expected, MDs whose care is being questioned often react negatively. [An in depth feature on Medicare's quality and utilization reviews will appear in a future *Illinois Medicine.*]

Who are reviewers?

Statewide, some 600 physician reviewers have aided CCFMC during its stint as the Illinois PRO. "We have roughly 300 physicians working right now in the metropolitan Chicago area, and our goal is to build to 500," notes Dr. Hyngstrom.

He claims "A strength of the program is *broadly* based peer review. We do not have physicians making their living doing reviews for us. This is Illinois' medical profession doing the reviews. The majority of PROs in the country do not have this level of peer review." They rely on a centralized operation with far fewer reviewers.

Considering the reviews are conducted by medical peers, why is the PRO being taken to task regularly? "No physician likes review," says Dr. Daw. "Very few understand the Medicare program or actually how the review is done. They don't understand that when they are asked for information, it doesn't mean there's going to be a sanction. I do think we're unfairly perceived."

Penalties: The bottom line

CCFMC recommends sanctions against hospitals or MDs only rarely. Since 1984, "we have issued seven sanction recommendations against physicians. We have conducted approximately 700,000 reviews," notes Dr. Hyngstrom.

Sanction recommendations are issued to the federal Office of the Inspector General for further investigation. The most severe penalty is elimination from the Medicare program. Civil monetary penalties are also potentially involved.

Another 150 doctors have been found by the PRO to have "an individual, serious problem or a large number of minor issues that are a pattern," Dr. Hyngstrom says. "Technically, we could have issued a sanction recommendation. Because of our approach to compliance, we're working on education, co-management, tutorials, self-defined restriction of practice and ongoing monitoring."

For example, the PRO found a family doctor whose practice was five percent surgical. All the quality issues related to surgery. After consultation with CCFMC, the physician agreed to drop his surgical privileges. "We eliminated the potential for that problem and we didn't deprive the doctor's patients of his services," says Dr. Hyngstrom.

As CCFMC's administrator, Dr. Hyngstrom sees "unfounded anxiety. We're looking for a *pattern* of serious problems that stand out."

Registering complaints

Physicians who feel they have been unfairly cited by Illinois' PRO have several avenues available to them. First and foremost is taking their case directly to CCFMC for review and appeal. The earlier the response, the better, according to ISMS experts who monitor PRO activities.

A second option involves calling or writing the ISMS Health Care Finance Division for assistance in getting to the bottom of a troubling situation.

"We have received complaints from physicians," says Dr. Kiessel. "We are willing to review those, and where valid problems exist, take them to the PRO." Having specific documentation is crucial.

But some situations are not easily resolved, acknowledges Dr. Rokosch. "Physicians are troubled by the PRO law itself." In the absence of any realistic ability to alter the law, ISMS has worked with CCFMC to ameliorate, where possible, the worst elements. "It's not as satisfying as denouncing the process, but it's ultimately more effective," he says.

From the PRO's perspective, Dr. Daw echoes that view. "The people in Washington, D.C. feel the PRO is a necessary program that's not going to go away. We're trying to minimize the intrusion on the physician." ▲

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UI/Reese pact reworked; "Metro" ties in jeopardy

by Kevin O'Brien

"WHAT HAPPENS now to the affiliation agreement with Michael Reese?" Although by no means the only question, it was the one that constantly hovered over a special meeting of the University of Illinois Board of Trustees on August 10. While the question was never directly answered, its importance was underscored by the revelation that three of the university's current affiliations may be in serious trouble.

"We are in a state of flux with our relationships with our metro hospital affiliations," executive vice chancellor James J. Stukel told board and faculty members, hospital staff, and other observers packing the university hospital's large ground-floor meeting room. "The problem is that there is some jeopardy with some of these affiliations."



Michael Reese Hospital and Medical Center: affiliation still a question.

Other affiliations delineated

Stukel is chairman of a special committee comprised of health sciences college representatives and hospital staff charged with developing specific plans for keeping the hospital open this year and beyond, and for reviewing the Reese agreement "to reflect current conditions." Although Stukel's report did not include recommendations regarding Reese, it did reveal the potential importance of a Reese affiliation to the university.

The university currently has affiliations with Cook County Hospital and West Side Veteran's Administration Medical Center, both located within the west side medical center district. While there is little short-term concern about these affiliations, the current federal review of veteran's health care facilities and County's continuing deteriorating conditions could have a future impact.

Of more immediate concern are the university's four "metro" affiliations. They include Mercy Hospital on Chicago's southeast side, Illinois Masonic Medical Center and Ravenswood Hospital Medical Center on the city's north side, and Lutheran General Hospital in Park Ridge. Of these, Stukel said only the Illinois Masonic affiliation is considered safe.

Stukel said, and faculty sources confirm, that Lutheran General is being seriously courted by the Uni-

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Photos: Wm. Daniels/The Photo Partners

Generic vs. brand name drugs: controversy grows with new probe

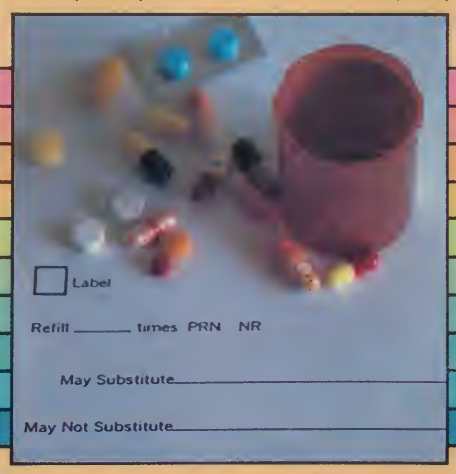
FROM THE outside, it appears a simple process, involving physicians and patients seeking treatment for their illnesses. From the inside, prescribing drugs is a complex process with many layers, a host of players.

The process may begin with suburban-Chicago based pharmaceutical rep Sue Schmidt informing physicians about Wyeth-Ayerst's Isordil chewable tablets, while Alan Cahn, Thorndale's Save-Rite pharmacist, decides which generic drug he will substitute for patient's Inderal prescription.

Further complicating the process are yet more layers in between, like the Food and Drug Administration (FDA), which establishes standards for generic substitution of brand name drugs. And then there is Congress, which simplified the FDA's generic drug approval process by introducing the Drug Price Competition and Patent Term Restoration Act of 1984, "a trade off bill that allowed for extended patent protection of brand name products in return for an easier admission of generics into the market place," commented Mark W. Stanton of the Health Policy International (HPI) in New Jersey. HPI is a nonprofit independent research organization supported by foundations, industry and professional associations.

Generic vs. Brand Name Drugs

These ten states have the largest volume of new prescriptions. Breakdown shows the percentage of prescriptions in which a generic drug was permitted by the physician and those in which substitution was prohibited. (Percentages do not add up to 100 percent because less than half of all prescription drugs have generic equivalents.)



State	Generic Substituted	Generic Prohibited
California	39%	2%
Michigan	38	5
New York	26	45
Ohio	25	7
Florida	24	6
New Jersey	23	38
Georgia	21	17
Illinois	20	49
Pennsylvania	18	41
Texas	13	53

Source of Data: Market Measures, Inc., West Orange, New Jersey, 1988.

Photo: Alexandra Buxbaum

Competition among prescription drug manufacturers has grown into a large portion of the process. Nearly some 100 pharmaceutical research companies nationwide spent about $600 million in 1970 for research and development of new drugs, according to Jeff Trewhitt, a spokesman for the Pharmaceutical Manufacturer's Association (PMA). "Since then, the brand name industry has doubled its research and development commitment every five years, spending $6.5 billion last year with an anticipated commitment level of $7.3 billion for 1989," he said.

Despite these efforts, consumer demand for lower-priced drugs has aided generic firms in battling their way up in the sales market. However, a more lenient enforcement of generic drug regulations put in place during the Reagan Administration may be taking the generic drug producing industry a step backward in the eyes of physicians and patients.

Recently, a federal investigation into criminal indictments accusing FDA officials of taking bribes from generic drug manufacturers to speed the approval process of their products has brought the issue of generic substitution to the forefront. Al-

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Views vary on authority of physicians at emergency scenes

by Franklin J. Kourt



"WHO'S IN CHARGE here?"

That's a question some physicians are asking when they come upon the scene of a medical emergency being attended by paramedics. The answer is determined by the protocol being followed by the individual emergency medical services system under which the paramedics are operating. There are 45 such systems in Illinois.

Leslee Stein Spencer is chief of the division of emergency medical services of the Illinois Department of Public Health (IDPH), which administers the Emergency Medical Services Act. Her agency provides guidelines to physicians who are project medical directors (PMDs), but PMDs are free to write their own protocols, subject to her department's review and approval. That means protocols may vary throughout the state.

ISMS resolution seeks rule changes

The subject of medical control at emergency scenes became an issue recently at the annual meeting of the ISMS House of Delegates when Wayne M. Leimbach, M.D., of Kane County sponsored a resolution seeking to clarify, through legislation or rule changes, the role of physicians who happen upon the scene of an emergency.

The resolution, as adopted by the House, asked ISMS, through its board of trustees or appropriate council, to "seek rule changes or legislation to clearly define the prerogative, authority and role of physicians at the scene of a medical emergency who have identified themselves. This definition shall include the liability issue."

Dr. Leimbach, whose specialty is internal medicine, said that he offered the resolution based not only on a recent Mike Royko column that told the story of a physician who was arrested while trying to assist a person with a gunshot wound, but for similar cases that he knows of.

"Somebody has to do something about this before we have a bigger accident," Dr. Leimbach said. "There has to be some provision where if a physician identifies himself he can step in."

An endorsement for revising the rules

Morgan Meyer, M.D. of Lombard, is among the physicians who endorse Dr. Leimbach's proposal.

He said he has experienced difficulty with private ambulance personnel and sometimes fire department paramedics, and that in some cases, even when it's his own patient involved he has not been allowed to take over.

"They [paramedics] can't possibly know more than the attending physician about his patient and it's not in the best interest of the patient or the public to have this type of attitude continue on the part of the variously trained and variously experienced paramedics," said Dr. Meyer, who acknowledges paramedics "can be very helpful at times."

He said that in the Lombard area there are fewer problems recently because he created a form that doctors can carry releasing paramedics from responsibility.

Dr. Meyer said he feels that at times precious moments are lost because protocols call for paramedics to start IVs.

"One of the biggest complaints I have is that they insist on starting IVs and sometimes it may not even be indicated. Many times it takes so long to start it that transportation of the patient is unduly delayed, which is counterproductive to the medical care," he said.

Spencer said her department's guidelines include having the physician positively identify him or herself and state their specialty. She said that after the hospital-based physician talks with the physician on the scene, the hospital-based physician may elect to relinquish control to the physician on the scene or share control.

"If the physician on the scene insists on taking control, the paramedics are to get the physician's name and license number and have it recorded over a tape at the command post hospital and usually they'll have the physician talk to the resource hospital. If they [resource hospital personnel] cannot convince the physician to relinquish control to the paramedics, they'll let the physician on the scene take care of the patient, but the physician must transport the patient to the hospital with the paramedics," said Spencer, adding that the guidelines include a provision for having the paramedics deny the physician at the scene access to their drugs if they feel their use would be detrimental to the patient or contrary to the standing orders of the system hospital.

Spencer said she would like to see the individual EMS systems make their policy clearly known to all doctors in their areas.

"I think that is definitely the key because, other than emergency physicians, most physicians don't understand or know EMS. It hasn't been around that long and they don't know the training and background of what goes into becoming a paramedic and the skills that they have," she explained.

Paramedic pioneer comments

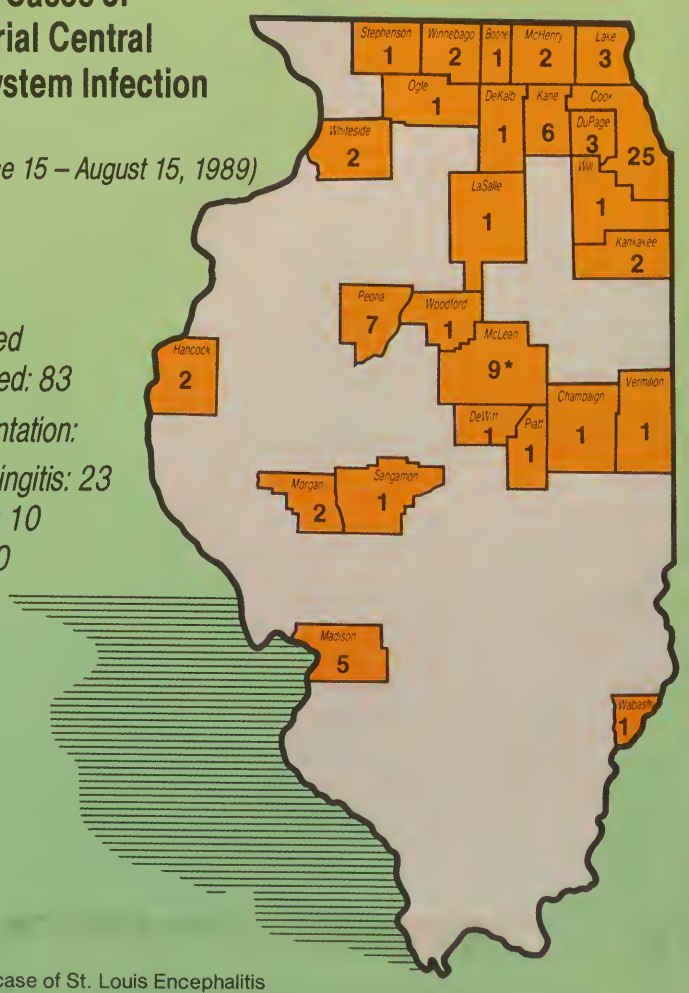
Stanley Zydlo, M.D., who started the first paramedic program in the midwest in 1972, is PMD of the Northwest Suburban Paramedic System and chairs the consortium that operates the Chicago paramedic program. He said that when people call for a paramedic they are getting a doctor, in the form of the physician at the hospital directing the paramedics by radio.

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Physician Facts

Suspected Cases of Non-Bacterial Central Nervous System Infection in Illinois

(By County, June 15 – August 15, 1989)



Total Suspected Cases Reported: 83

Clinical Presentation:

Aseptic Meningitis: 23
Encephalitis: 10
Unknown: 50

* One confirmed case of St. Louis Encephalitis

Source of Data: Illinois Department of Public Health

Physician/ paramedic views control issue

by Franklin J. Kourt

NOT MANY PEOPLE can literally look at the issue of medical control at emergency scenes in the shoes of both the physician and the paramedic. Andrew Basile, D.O., is one of the rare ones who can.

Dr. Basile, 32, is a former full-time paramedic currently in his third year as an emergency room resident at Chicago Osteopathic Hospital, while continuing to work part time as a paramedic in Schiller Park and at the Rosemont Horizon.

He said that while, as a physician, he can see the point of doctors who want to be able to take medical control of an emergency situation from paramedics, he does not feel it should be done unless the physician is the patient's personal doctor or can in some other way significantly add to treatment of the patient at the scene.

"If paramedics made the first contact [with the patient] then I say they should not yield control of the patient because that contact constitutes a physician/patient relationship based upon the paramedics' contact with the base hospital," said Dr. Basile, adding that he feels this relationship should not be interrupted unless the patient's personal physician arrives on the scene or a physician who is board-certified in emergency medicine and who could add significantly to the patient's treatment shows up.

Dr. Basile said it was while working as a paramedic in the emergency room of Lutheran General Hospital, Park Ridge, several years ago that he decided to become an emergency room physician.

"I went to medical school so that I could be an emergency room doctor and so that I could continue in the paramedic field. That's why I've stayed certified [as a paramedic] and that's why I stay active. My plan is to eventually run my own paramedic system, figuring that there's no better way for someone to run a paramedic system than to be somebody who's come up through the ranks," Dr. Basile explained.

He said the hardest thing about going to medical school after years of professional experience in the field as a paramedic is having to learn the basic science background information.

"There are a lot of things taught to provide background information you don't actually use clinically. It was difficult for me to be motivated to learn that material, based on the fact that I could see very few clinical applications," Dr. Basile explained. ▲

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Thompson, Daley, Dunne join to convene health care summit

by Kevin O'Brien

IN WHAT THEY dubbed a landmark announcement, Gov. James Thompson, Chicago Mayor Richard M. Daley and Cook County President George Dunne are jointly convening a summit to attack the problem of health care delivery for the medically indigent of Cook County.

The summit is charged with proposing solutions to problems posed by a delivery system comprised of the deteriorating Cook County Hospital, neighborhood clinics run by the Chicago Department of Health, and a network of private neighborhood clinics, none of which are efficiently coordinated.

"It is clear to us that this kind of fragmented system of health care delivery no longer efficiently and compassionately serves the people in this county," Thompson said in an August 23 Chicago press conference. Joining the political leaders were Chicago's new Board of Health President Whitney M. Addington, M.D., and Acting Health Commissioner Richard Krieg, Ph.D.

"For too long the city, the county and the state have struggled separately with what should be, after all, a shared responsibility," Daley said. "Through this summit, we'll build a model system of coordinated and successful health care focusing on low-income families and the working poor." Convening such a summit was one of Daley's campaign promises.

"I welcome the opportunity to participate in this, if I can use the expression, 'trifecta,' hopefully ferreting out the problems that exist, and to expedite the delivery of health care in Cook County," said Dunne.

Two working groups comprised of experts in public policy and health care delivery will be appointed within days of the announcement, Thompson said. It will be up to them to recommend any structural or governmental changes, as well as identify necessary additional funding.

Daley said that the public policy steering committee will hold public hearings before devising a short-term and long-term health care agenda. The system design and management committee will then recommend the specific steps for implementing the proposed agenda.

Thompson said the four legislative leaders will be invited to designate representatives. Input will also be sought from the Chicago Medical Society, Illinois State Medical Society (ISMS), Illinois Hospital Association, Metropolitan Health Care Council, and community and private health groups.

The working groups are to complete their work by late October so that legislation can be drafted for introduction to the General Assembly this spring. Thompson said the goal is to have a new system in place sometime next summer.

Thompson cited the change in Chicago's mayoralty, an urgent need to resolve controversy over the county's future role in health care delivery, the state's recently improving economic picture, the increasing demand on both federal and state governments to address the plight of the nation's uninsured and under-insured, and increasing health care cost-consciousness in both the public and private sectors as factors in the timing of the summit.

ISMS Chairman Harold L. Jensen, M.D., welcomed the summit, but cautioned against unrealistic expectations. "Everyone agrees the problems are real and urgent, but solutions, especially questions of funding, are much easier to cite than to solve." Dr. Jensen will sit on the public policy committee, while ISMS Executive Vice President Alexander R. Lerner will work on the systems and management committee. ▲



Photo: Richard Ferguson/The Photo Partners

Gov. Thompson signs Senate Bill 150 at Loretto Hospital on Chicago's west side. Sponsored by Senate President Philip Rock, (D-Oak Park), the bill provides an additional $55 million to 46 Illinois hospitals that serve a disproportionate share of Medicaid patients.

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

ADDITIONAL INFORMATION — RADIATION THERAPY/WEEKLY TREATMENT MANAGEMENT

The radiology fee schedule became effective for services performed on and after *April 1, 1989.* The radiology fee schedule does not provide for *daily* radiation treatment management. The only treatment management services to be reimbursed under the fee schedule are *weekly* treatment management services (procedure codes 77420, 77425, & 77430).

A *weekly unit* of treatment management is equal to 5 fractions (treatments). Bill one unit for weekly treatment management *only when* 5 fractions have been provided, regardless of whether or not those fractions are on consecutive days. Show "From" & "To" dates of service covering each 5 fractions (1 unit) in Box 24A on the HCFA-1500 claim form.

If at the final billing of the treatment course, there are 3 or 4 fractions beyond a multiple of 5, those *final* fractions should be billed as one unit. If there are 1 or 2 treatments beyond a multiple of 5, the carrier will consider payment for those services as having been made within the payment for the last weekly unit of treatment management, and they should *not* be billed separately.

If only 1 or 2 fractions are provided and treatment is then discontinued, the carrier will pay one-half (1/2) of the amount paid for 1 week. Indicate on the claim *why* treatment was discontinued.

Services described by procedure codes 77300-77399 were *not* included in the development of relative values for weekly radiation treatment management. These services are defined as the "technical components", or the services of technicians. They are not the "professional component", or the services of a physician.

According to Medicare Carriers Manual (MCM) 2050 & 2075, the service of a technician may be paid when rendered "incident to the physician's services". The technician *must* be in the physician's employ; the physician *must* be present in the area, immediately available to provide assistance & direction throughout the time the procedure is being performed.

Therefore, payment for the services of the technician depends of the *place of service:*

- Inpatient hospital — separate reimbursement is denied by both Medicare A & Medicare B. These services are included in the DRG paid by Medicare A under the Prospective Payment System. Services of technicians (ie., non-physician services) must be furnished directly or under arrangement by the hospital.
- Outpatient hospital — payable to the hospital by Medicare A under the radiology relative value scale blended rate. Services of technicians (ie., non-physician services) must be furnished directly or under arrangement by the hospital.
- Freestanding facility — payable by Medicare B outside the weekly treatment management reimbursement under the radiology relative value scale as technical component services when the *technician is employed by the physician.*

When billing for weekly radiation treatment management (77420, 77425, 77430) or procedure codes 77300-77399, follow the instructions outlined below:

- If Place of Service (POS) is Hospital Inpatient (POS-1) or Hospital Outpatient (POS-2), bill the appropriate weekly treatment management procedure code with Modifier *26* which indicates "professional component only". The fee must also reflect "professional component only", for the services of the physician.
- If Place of Service (POS) is a Freestanding Facility (POS-3), bill the appropriate weekly treatment management procedure code, *no* modifier, and the global fee. The technical component is a freestanding facility is billed with Modifier *TC* which indicates technical component only, for procedure codes 77300-77399, for the services of a technician employed by the physician. The fee must also reflect "technical component only", for the services of the technician.

We are currently making changes necessary to permit payment for procedure codes 77300-77399 in a freestanding facility *only.* If you have billed for these procedures and been denied payment for dates of service April 1, 1989 and after, you may submit these claims for review on or after *August 1, 1989.*

UPDATE — ICD9 DIAGNOSIS CODING FOR PHYSICIANS

ICD9 diagnosis coding on claims for physicians' services is required. Health Care Financing Administration (HCFA) has determined that 90% of all Medicare claims from physicians are ICD9-coded. For this reason HCFA has temporarily removed the requirement that the carrier deny or develop a claim received without an ICD diagnosis code. Keep in mind ICD9 diagnosis coding is *required* on your Medicare claims. You should *not* use this temporary delay in denial or development as an opportunity to eliminate ICD9 codes from your claims.

(This report is a service to the physicians of Illinois)
9/1/89

Editorials

Measles: a preventable public health problem

Just when society was lulled into thinking we'd banished the perilous "childhood diseases" of yesteryear, Illinois is battling its worst measles outbreak since 1978. State and local health agencies deserve credit for quickly launching intensive anti-measles outreach efforts. But, this epidemic was preventable.

Soon after initial case reports, it became apparent the disease hit hardest in neighborhoods where many residents don't know the importance of preventive health care and immunization, particularly for preschoolers, and where access to medical care may be a serious ongoing problem due to economic or language barriers. Adding to the public health hazard, some adult Illinoisans don't realize they're at risk for measles because they've lost childhood medical records which could have revealed whether they've had measles or not. Therefore, they don't know whether they need to be vaccinated.

Unfortunately, this year's outbreak shows that measles hasn't left the scene. It must still be taken seriously as a potentially life-threatening public health issue. We should use this tragic epidemic to impress upon patients their responsibility to obtain necessary immunization promptly for themselves and their families. ▲

Generic drugs: what you see may not be what you get

The Food and Drug Administration must act quickly to get its house in order by retesting generic drugs on the market to assure they meet approved bioequivalency standards, not just safety standards. The pharmaceutical industry has traditionally shared a mutual, trusting relationship with physicians who depend on the safety and efficacy of the "name brand" drugs they prescribe for patients. When generic drugs began to compete in the marketplace, offering lower costs to patients, the medical profession accepted the concept, with the caveat that therapeutic effectiveness—and not cost alone—should determine which drug to provide.

We and our patients deserve full assurance that generic drugs comply with strict manufacturing standards, and that they pass stringent bioequivalency tests showing they are as effective as the brand-name version. Dispensers of drugs also bear a heavy responsibility to assure safety. To that end, ISMS has actively opposed legislation authorizing pharmacists to independently dispense pharmaceutical or therapeutic substitutes to a physician's prescription.

We encourage the FDA to conduct increased focus reviews of suspect products, while physicians step up our followup with patients to assure that the drugs we prescribe are doing their appropriate job. ▲

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Guest Editorial

The Linares case and the law



by Max Douglas Brown

In his guest editorial (June 23, 1989, *Illinois Medicine*), Steven Miles, M.D., of the University of Chicago Medical Center commented upon the much publicized case of Sammy Linares. The caption given his commentary, "Why lawyers should not practice medicine . . . and why doctors must," accurately communicates the substance of his position. His message to physicians is clear. "Don't trust lawyers. Don't trust the law. Take custody of medicine in the same way that Rudy Linares took custody of his son." It is an emotionally charged commentary in which he condemns the handling of the case by Rush-Presbyterian-St. Luke's Medical Center.

He is not the first medical ethicist to comment on this case or criticize Rush-Presbyterian-St. Luke's Medical Center relative to this matter. What is disappointing is not that our institution should be criticized. We are certainly not immune to criticism. What is so astounding is that he and a handful of other medical ethicists would comment on a clinical situation about which they really know very little.

He has used a tragic event to picture lawyers practicing medicine and doctors abdicating their role. He portrays the interests of the hospital as being contrary to family and physician. As to this portrayal, his commentary is both unfair and untrue.

Our job as hospital legal counsel is to advise, not to direct. Our function is to provide alternatives and options, not to limit them. Our whole purpose is to protect physicians within our institutions, not to speculate with their careers as to criminal prosecution. I consider the interests of physicians and hospitals to be complementary, not contrary to one another. We stand with physicians to use Dr. Miles' own phrase, "in fortune and misfortune."

I am obligated to advise doctors as to what the law is, not what I would like it to be. The fact is physicians face limited options in our state as to the withdrawal of life support systems, especially where children are involved.

Physicians should be aware of the complete set of options that are available to them as to the withdrawal of life-support systems and the possible consequences as to each course of action. One option is to remove a patient from a life-support system if there is either cessation of the cardiopulmonary system or brain death. A second option is to remove a patient from a life-support system if there is a clear prognosis and the patient is an adult who has given an advance directive indicating a preference. In the absence of either of these, a patient may be removed from a life-support system upon a court order.

If death has not occurred, if the prognosis is not clear, if an advance directive has not been given, or if a court order has not been obtained, the removal of a patient from a ventilator in Illinois could be construed as medical malpractice, reported as child abuse (if a child is involved) or criminally prosecuted as first degree murder.

The Criminal Code and the Child Abuse and Neglect Act make no exception for doctors who believe they are acting in good faith, who are doing what is ethically correct, who are simply following the requests of distraught parents, or who are pursuing the humane and compassionate recommendations of an ethics committee. Nor, to date, is there any judicial opinion in Illinois which would allow a doctor or nurse to remove a child who is not brain dead from a life-support system.

While I agree with Dr. Miles that no hospital has been successfully prosecuted for the termination of treatment, I am sure that he must realize that this statement carries with it the admission that there is the legal basis to do so. He suggests that physicians can "quietly and legally" remove life-support systems. But if the removal is legal, why does a physician have to do it "quietly"? The fact is, depending upon the circumstances, it may not be legal and there may be both civil and criminal liability in doing so.

To establish a true consensus and to provide the optimal protection for physicians, legislation must be adopted to assure that the rights of all concerned are truly respected. Until the adoption of this legislation or clarification by our state's judiciary, encouragement of physicians to circumvent the law, to avoid the law, to ignore the law or, even worse, to be ignorant of the law is not the answer and cannot be the answer. ▲

Mr. Brown is general counsel for Rush-Presbyterian-St. Luke's Medical Center, Chicago.

ABORTION

Illinois Medicine *recently invited readers to share comments on the controversial abortion issue. The following were received in time for publication in this* Illinois Medicine. *Additional letters will be published in future issues as space permits.*

The recent Supreme Court decision in *Webster* vs. *Reproductive Services* which allows states to individually control access to abortion will have a significant impact on our medical system. The decision has the potential to limit the availability of medical care to certain sectors of the population. The limitations would be dictated by factors such as economic status, and place of residence—factors which until now have not been the *de jure* criteria which determined accessibility to care.

The decision will have the effect of creating fifty different sets of laws and regulations for the treatment of the same medical condition—pregnancy. The result will be that certain treatments will be available in some jurisdictions and not in others; and that even where a particular treatment may be available, access to it may be limited by an arbitrary criterion such as economic status. Without saying that abortion is right or wrong, the fact that access to this procedure will be determined by other than medical criteria is wrong.

As the standard of medical care in any community is increasingly compared with the standard in the nation as a whole, it seems absurd and immoral to deliberately create fifty different standards of care.

This decision will serve to entrench a tiered system of medical care in America. To deny people access to certain levels or intensity of medical care based solely on criteria which have nothing to do with their medical condition is discrimination in one of its basest forms. We have laws to prevent discrimination based on age, race, sex, etc. What the government is now saying is that while it is illegal to discriminate based on some criteria, it is perfectly legal to discriminate based on other criteria. In addition, the decision has the implication of banning discrimination in the private sector while countenancing it in the public sector.

Our Declaration of Independence's "equality" must include equality of opportunity, and we must insist that this include equality of opportunity for and access to medical care.

It is important that we physicians educate our patients about how the consequences of this decision can make them (our patients) "less equal," and ask them to join us in petitioning our legislators (both federal and state) to take action to preserve our quality care medical system and to oppose any effort to convert it to a tiered system of medical care.

George I. Goldstein, M.D.,
Libertyville

Illustration: Michael Jones

On abortion as in most other issues, the best course of action is the middle of the road. I neither support abortion as a routine form of birth control, nor the banning of all abortions.

The usual pro-life position of regarding all abortions as murder is untenable for the following reasons:

- Life does not begin at conception. Biologically, both the spermatozoon and the ovum are living cells long before fertilization. Millions of spermatozoa are left to die in every ejaculation or whenever their normal life span in the seminal vesicles expires. What does begin at conception is a new being with the potential of developing into a full person.
- The question really should be "When does personhood begin?" Most physicians and many courts of law consider an adult with brain death something less than a full person and a candidate for withdrawal of unusual means of life support. Why should an anencephalic fetus, even after the first trimester, be considered more of a person than a fully developed adult who has had a massive stroke?
- The argument that a fertilized ovum is a person just because it has a full complement of chromosomes is equally absurd. Thousands of epithelial cells, all with a full complement of chromosomes, are scraped off our mouths every time we brush our teeth, or rubbed off the intestinal mucosa after every meal. Pro-life groups are not complaining about this killing.
- The concept of relative worth of life is well ingrained in our society. Most pro-life advocates are not vegetarians and do not oppose pest control, suggesting that they believe the value of animal life to be less than that of human life. I believe that the value of life after conception increases gradually as this embryo develops into a full person. Interestingly, in my experience, funerals for products of conception aborted spontaneously during the first trimester are uncommon even among strong pro-life supporters.
- To say, as Missouri's anti-abortion law does, that the unborn is entitled to "all the rights, privileges and immunities available to other persons" creates the dilemma of jailing pregnant women. In fact, a lawyer in Jefferson City has just filed suit contending that the state is illegally imprisoning a female inmate's fetus. If he wins his suit, this will create a tremendous incentive for female prisoners to become pregnant in order to be freed.

On the other hand, abortion should not be used as the birth control method of first resort, despite the fact that maternal mortality from medically performed first trimester abortions is lower than that for childbirth. I also agree that adoption should be considered far more often by the unwed mother and the childless couple than now occurs. Paradoxically, one of the reasons for the large surplus of black and Hispanic children awaiting adoption is that some white anti-abortionists seem to place a lesser value on human life with dark skin.

If the resources of pro-life organizations could be invested instead in sex education, including planned parenthood, most unwanted pregnancies might not occur in the first place. The problem is that many who oppose all abortions also oppose sex education and most good methods of birth control. This shows that the abortion controversy is more of a religious matter than a medical, social, or even moral issue. To that extent, the state should not legislate abortion because the Constitution mandates that the state do nothing to either oppose or establish a religious point of view. The individual right to make choices in this domain must be preserved.

As a physician, I believe that any law banning all medical abortions would negate the benefits of most advances in prenatal diagnosis of genetic and metabolic abnormalities, unduly intrude in the doctor-patient relationship, and violate the rights of the pregnant woman.

Erlo Roth, M.D.
Burr Ridge

In all pregnancies, as in all life, we should be able and willing to face and live by the truth and not succumb to the desire alone for pleasure or money or the determination to have our own way.

If we are willing to accept and live by what is true, we must decide whether the embryo or fetus is 1) living, 2) human. The embryo or fetus must be living and growing or there would be no argument. They are certainly and beyond all doubt human, not dogs or cats or other animals.

It follows, therefore, that abortion kills, or more graphically, executes a living human since it is done for an ulterior motive.

Some may argue that the state may execute a convicted criminal and consider this a right; or a private person may protect an innocent life by killing an unjust aggressor. The embryo or fetus cannot be regarded as an unjust aggressor. So the only question is regarding the "right" to kill a human who has done no wrong.

The answer is self evident. No one has this right.

If we do not live by what is true and right, then we place ourselves with Hitler or the Greylord judges or the commodity traders who have cheated their customers.

And so crumbles the whole fabric of society.

These are harsh words, but abortion is a still harsher act no matter how we try to disguise it by twisting and distorting the language.

Thomas J. Stamm, M.D.
Elmwood Park

The state should only move to restrict abortions if the present medical performance of abortions has been shown to result in deleterious outcomes for a significant number of patients who have undergone the procedure. Since Dr. Koop was unable to demonstrate significant adverse effects of abortion on patients in a review of the available literature, I sincerely doubt that Illinois will be able to muster significant medical evidence on behalf of restriction of abortion. One must perforce look for reasons, other than medical, behind the drive for restriction. It is always disturbing to find any group (even a minority) attempting to place restrictions on the rest of the population. It matters not if they themselves feel that their motives are ennobled by religious or moral considerations—they have placed themselves beyond the pale by attempting to impose their beliefs and values on others, who do not share them. The move to restrict abortions in Illinois is merely the first step in invading the privacy of others and in restricting the right of others to make personal decisions. For a compelling vision of the future under a restrictive system, one should read the best seller "The Handmaid's Tale," by Margaret Atwood. ▲

D. F. McLaughlin, M.D.
Park Ridge

Part 2

Defend or settle?

by Fred Z. White, M.D., Chairman, Illinois State Medical Inter-Insurance Exchange

The second of two articles on professional liability issues

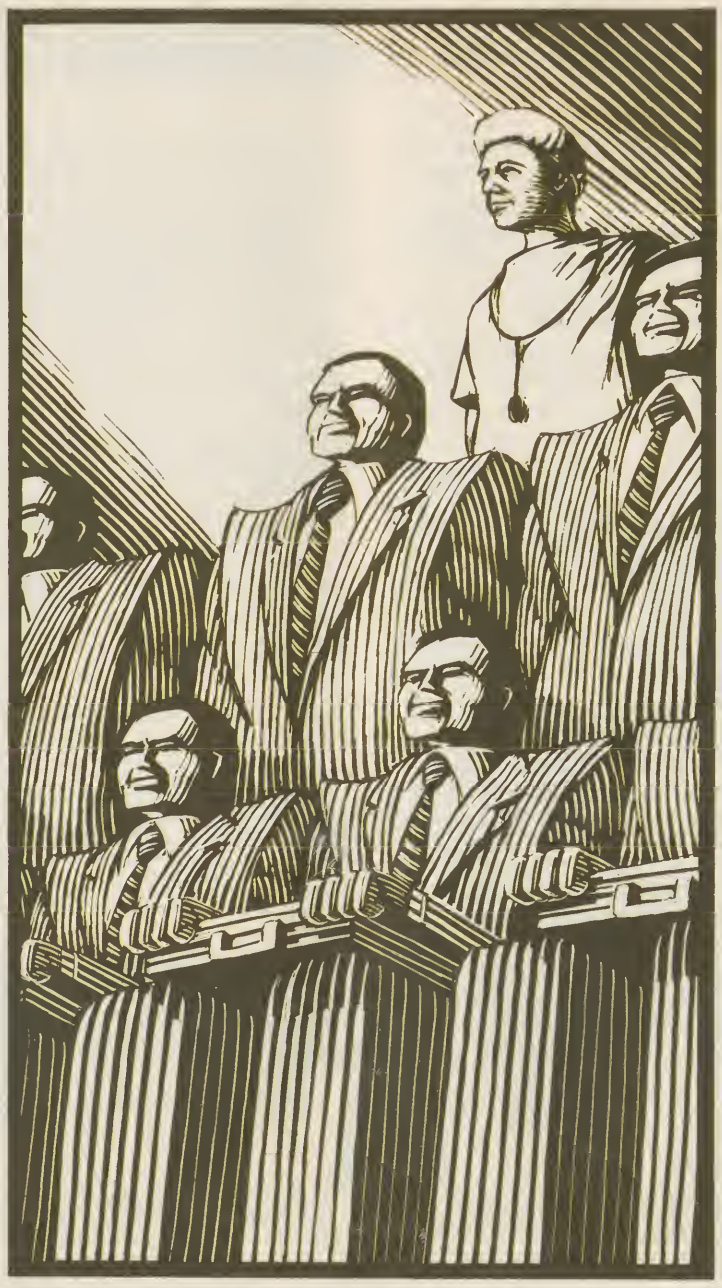


Illustration: Bob Dahm

WHEN EVALUATING whether to defend or settle a claim, the positives and negatives must be weighed and considered for the individual case. This requires a certain degree of experience and objectivity. The physician review committee members and ISMIE professional liability analysts have experience reviewing hundreds of claims and following many of them through to resolution. They assist the insured physician to evaluate objectively the claim and the defense position.

Experienced malpractice defense attorneys familiar with the applicable local courts are chosen to represent ISMIE insured physicians. You may receive advice from your personal attorney or friends who are lawyers, but remember that attorneys are as specialized in fields of law as physicians are in their medical specialties. You should not disregard the advice of your specialist in the malpractice defense field. Many defensible cases are settled because the defendant simply cannot be relied upon to follow the advice of the defense attorney. Failure to cooperate with defense jeopardizes the physician's ability to remain insured by ISMIE.

There are many emotional factors associated with being sued. It is not uncommon for the physician defendant to have trouble separating the emotional aspects of the claim from objective facts. However, it is essential that the physician be able to do so when participating in the decision to settle or defend a claim. In some rare cases, the physician is never able to do this. For the protection of the physician and other policyholders, the Physician Review Committee has final authority to make settlement/defense decisions where disagreements with the physician defendant policyholder cannot be resolved.

Significance of indemnity payments

A malpractice indemnity payment is a serious consideration for a physician, as the payment will appear indefinitely on the malpractice claim history of the physician. An adverse claim history with payments for multiple or serious claims will impact negatively on future insurance and premiums. In addition, indemnity payments are required to be reported to the Illinois Department of Professional Regulation for use in licensure and disciplinary actions. The proposed National Data Bank for physician practice monitoring will also permanently record paid claims on the record for the individual physician.

If a claim is clearly defensible, it would be in the physician's best interest to defend the case in the hopes of avoiding an indemnity payment. Defending non-meritorious claims has been a long-standing policy of ISMIE, successful in discouraging these claims. The physician who demands to settle when the claim is defensible jeopardizes his ability to remain insured with ISMIE, because he has not fulfilled his obligation to himself and his fellow policyholders to cooperate in his own defense and to support the aggressive defense policy of the Exchange. The Physician Review and Evaluation Panels (PREP), physician policyholders who review policyholder coverage decisions, consider the demand to settle in the face of a defensible claim a serious breach of faith with the Exchange.

In situations in which it is clearly not advisable to defend a claim, attempts to view unrealistically the exposure and defend the claim may result in an excessive jury award. A settlement with the plaintiff could have controlled and minimized the amount of indemnity payment on the physician's claim record.

Not every case will be clearly a liability or no liability situation. Therefore, all factors for the individual claim must be considered in making a decision to settle or defend. In some cases, settlement may be recommended, but if the plaintiff's demand is unreasonable, it may force defense of the claim. The payment of unreasonable settlement demands sets a dangerous precedent that encourages future excessive demands.

The decision to settle represents a desire to minimize the severity of the claim by controlling the cost. If it can be avoided, it is best not to rely on an unpredictable jury to determine the value of the claim when liability exists or the case is otherwise indefensible.

ISMIE defend/settle policy

The Exchange was founded on the belief that the best way to discourage unfounded malpractice suits is through aggressive defense. It may have cost more in expenses to defend some of the claims than it would have cost to settle, but the additional expense is considered to be an investment in the prevention of future claims. Plaintiffs' attorneys know that they will not get an "easy settlement" from ISMIE for a non-meritorious claim, so this investment has paid off.

Over time, the Exchange has been successful in resolving approximately 80 percent of all closed claims without an indemnity payment. Of the three percent of claims that go to trial, 75 percent are resolved in favor of the defendant.

Informed decisions

Due to the unpredictable nature of malpractice liability, there is no set procedure that will guarantee that the decision to settle or defend is the right one. But the best informed decision possible can be made by taking the time to evaluate the claim objectively, using the advice of experienced medical, legal and insurance professionals.

Exchange resources

ISMIE provides the following resources to help physicians prepare to deal with a lawsuit.

Videotapes available for free 14-day loan:

- The Physician Defendant: Your Deposition
- The Physician Defendant: Your Trial
- The Role of the Expert Witness
- Anatomy of a Claim
- Anatomy of a Malpractice Trial

Brochures available:

- The Physician Defendant: Your Deposition/Trial
- The Role of the Expert Witness
- Coping With the Stress of Malpractice Litigation

Physician support group:

Individual counseling and support group discussions are available to assist the physician in dealing with the stress of a lawsuit.

For more information on any of the above resources, contact the risk management department, Illinois State Medical Inter-Insurance Exchange at (312) 782-2749 or 1-800-782-ISMS. ▲

Exchange Q & A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *Could you please explain how premiums are determined for corporate and partnership policies?*

A: The partnership/corporation quarterly premium is based on the sum of 5% of the individual quarterly premiums, at the limits of liability requested, of each partner, officer, director, or shareholder. This amount is also subject to:

1. A *maximum* of the average of the five highest rated physician partners', officers', directors', or shareholders' individual quarterly premiums, as calculated above.
2. A *minimum* of $100 per calendar quarter.
3. Additional charges for paramedical employees, etc., are also taken into consideration.

Q: *When should I notify the Exchange of changes affecting my policy that I would like to be made on my renewal policy?*

A: It is important to notify the Exchange in writing of any changes in your practice as soon as you become aware of them. Changes can be reported to underwriting department any time before the renewal date. Change request forms are a convenient way to report changes. The forms can be requested from the underwriting department. ▲

Medicare preadmission approvals process can be eased, says PRO

WHEN TELEPHONING the state peer review organization (PRO) to obtain pre-authorization as required by federal mandate for certain surgical procedures, physicians' office staff can facilitate the process by being prepared to answer several pertinent questions, according to Stephen Kaufman, chief operating officer for review services at Crescent Counties Foundation for Medical Care (CCFMC), the Illinois PRO. Having the necessary patient information at hand when calling the PRO will enable the agency to expedite review and provide an authorization number quickly," he said.

Under Health Care Financing Administration (HCFA) regulations in effect since April 1, (and explained in the April 28 *Illinois Medicine,*) preadmission approval is required to certify "medical necessity and quality of services" for ten Medicare "elective" procedures, whether they are performed on an inpatient or outpatient basis. HCFA defines "elective" procedures as those which can be scheduled. Emergency procedures can be performed without prior approval. However, those cases will be reviewed prior to payment by Medicare.

The procedures subject to this precertification process include cholecystectomy; carotid endarterectomy; major joint replacement; coronary artery bypass with graft; percutaneous transluminal coronary angioplasty; laminectomy; complex peripheral revascularization; hysterectomy; prostatectomy; and cataract.

Procedure criteria important

The specific preauthorization criteria outlining surgical indications for each of these procedures were sent to all Illinois surgeons in March, Kaufman noted. Before requesting precertification from Crescent Counties, the physician's office staff should consult the criteria for that particular procedure, Kaufman said. "If they are familiar with the criteria [for the specific procedure], they will know what we'll be looking for." Additional copies of the criteria are available from CCFMC.

Crescent Counties guarantees that every case is reviewed within 48 hours, said Kaufman. "We attempt to do it within 24 hours," he added. Since the system went into effect April 1, the PRO is handling "10,000 calls a month—close to what we projected," he said. So far, "The program has worked well. The majority of cases are approved at the time of the call." "We're not aware of any surgery having been cancelled because of inability to obtain a preauthorization number."

As expected, said Kaufman, nearly all calls being received fall into the elective surgical category. The agency "expects that quality of care considerations in an emergency situation supersede the preauthorization process. The intent is not to put the physician in the position of saying 'I can't do the procedure because I can't get the number.' The patient's well-being is the first consideration."

Physicians or office staff may obtain additional information by calling Mary Kreie, director of Medicare review services at CCFMC, at 312-357-8770. ▲

Have information ready

Keep handy the following "generic" information which you will need to provide the PRO review coordinator a prompt review:

- State a clear reason for the procedure, and provide any diagnostic test results supporting the need for the procedure.
- Describe the patient's physical status, to determine his or her stability for surgery. This indicator is used to determine if the patient is free from organic disease or systemic disturbance. Depending on the patient's status, the case may need to be referred to a physician reviewer before approval can be granted.
- Provide the patient's demographics, including name, address, telephone number. Providing the patient's correct Medicare identification number at the time of the call is especially important.
- Indicate the scheduled date and place where the procedure will be performed, including the hospital provider number, if known.
- Explain the scheduled surgical site. (Indicate "upper quadrant, left side," for example).
- Provide a phone number where the surgeon can be reached to respond to any questions from the reviewer. Cases in which approval cannot be made during the initial screening are referred to a physician reviewer in the same specialty as the physician performing the procedure in question, for further discussion before approval or denial of the case. ▲



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(continued from page 1)

though so far, the investigation pertains to only a handful of all the generic drugs approved each year in the nation, federal health officials say in the next several weeks, they will test the top 30 generic sellers for safety, involving hundreds of companies and more than 1,000 samples.

"There's been an explosion of generic products and generic companies, and a great deal of competition between them as to who can get on the market first. These short cuts may have been attempts to cut corners to get on the market early," said FDA spokesman Bill Grigg.

FDA policy

FDA requires generic drug manufacturers to "submit evidence that the generic, which has the same active ingredients, is bioequivalent to the original, that it will act in the body in the same manner, and to the same degree, as the original product," according to the FDA report on bioequivalence of generic drugs. However, generic drug manufacturers are not required to repeat all studies completed by the maker of the original drug to prove bioequivalence.

The report also stated the FDA "supports the long-standing policy that if a drug product is declared by the agency to be therapeutically equivalent, a physician, in managing a patient, can feel secure that authorizing substitution of that product for any other therapeutically equivalent drug will provide the same intended effect."

Despite FDA guidelines, those who have studied generic substitution remain wary. "The FDA has maintained in its standard, that up to 20 percent and in some cases a 30 percent difference in bioequivalency from the brand name product would not be expected to cause any differences in therapeutic effect when the product has been substituted for the one originally prescribed," said Leroy L. Schwartz, M.D., HPI president.

"However, it is clear that differences in bioavailability (the rate and extent to which the active chemical ingredient of the drug product reaches the bloodstream) of 20 to 30 percent from that of a standard product means it is possible for patients taking medication on a continual basis to receive a product with a bioavailability of 30 percent below the standard at one pharmacy and a refill of the product having a bioavailability of 30 percent above the standard," he said. "Under those circumstances, patients may experience a difference of at least 60 percent in the amount of the active ingredient absorbed from one product to the other."

"There are also many products in the market place being substituted for the product prescribed which have never had any bioavailability testing at all," added Dr. Schwartz.

PMA vs. GPIA

Jay Molishever, a spokesman for the Generic Pharmaceutical Industry Association (GPIA) responded. "After a brand name drug has been used for 17 years (the amount of time they are patent protected) in billions of patients, the same amount of money and tests to prove safety and efficacy of generics would be a waste of scientific resources. Doctors need to know that the generic version is safe, effective and bioequivalent."

Trewhitt said, "Physicians prescribe brand names because there's a documented performance record."

Pharmaceutical reps: Advertising the product

Also part of the prescribing process are pharmaceutical reps. They target both physicians and pharmacists to introduce products. "It takes work to change a doctor's mind to switch drugs,'' according to Schmidt. "Sometimes we help a lot and other times, physicians use what their colleagues use and they'll stick to that product."

Schmidt said medical advertisements influence physicians to an extent. "However physicians say they want to see more detailed information on the ads. Doctors say to me, 'Don't show me Madison Avenue glossy prints, show me ads that have studies that mean something to me.'"

She added "Most doctors I've spoken to don't appreciate the pharmaceutical companies who market to the public. They prefer that advertisements only be in medical sources."



Generic drugs available to consumers soared after passage of congressional legislation in 1984.

Source of Data: U.S. Food and Drug Administration

Which will they choose?

Despite all that goes on in the process of prescribing drugs, physicians are regarded as the key players. When physicians were asked which they prefer prescribing to patients, generic or brand name drugs, their preferences varied.

"My preference is to prescribe brand name drugs because of the consistency, composition, effectiveness shown over the years and for liability reasons. But, there is a lot of pressure from insurance companies and patients to switch to generics, because generics are cheaper," said Imtiaz Hamid, M.D. a cardiologist in Harvey.

"The cost of medication has really skyrocketed over the last several years. It's not too uncommon for us to have a patient with a cardiac disease, hypertension and diabetes on $150 worth of drugs a month," added Jay Walther, M.D., an internist in geriatrics in Flossmoor. "The cost of these drugs seems to far exceed the cost of other medical services we provide for these patients. Because of this, we want to give them the most effective and cheapest drug available, which many times is the generic," he added.

"I usually prescribe brand names because they are easier to remember, but allow substitution with generics knowing the pharmacist will give the patient the drug with the best price," according to Gerald D. Suchomski, M.D., a Springfield family practice physician.

David Steward, M.D., a general internist in Springfield said, "I generally prescribe generically, and when I don't, I allow patients to get the generic form."

Filling prescriptions

Pharmacists may fill a prescription with a generic medication, provided the product is listed in the Illinois formulary for drug product selection, and they follow certain criteria. The Illinois Department of Public Health (IDPH) issues the formulary which lists substitutable drugs.

In order for the pharmacist to substitute a generic for brand name drug, the doctor must give permission to substitute by checking off "may substitute" on the prescription. The pharmacist also must inform patients the physician has allowed for substitution, obtain patient permission before filling the prescription with a generic, and assure that the unit cost of the generic is less than the brand name. If a physician forgets to check off one of the two boxes indicating a preference for a brand or generic drug, the pharmacist may call the physician or decide himself whether to substitute with a generic, provided the patient consents. Brand name drugs may have several substitutable generic brands. Most pharmacies stock only one or two, depending on from which wholesaler the pharmacy buys.

Lawrence Slotnik, a 13-year drug coordinator for the state of Illinois said, patients have become more aware of generics since such companies as Walgreens and Osco started advertising generics, "and they prefer the less expensive drug. However, there are some skeptical patients who insist on brand names."

Hospitals

The choice of prescribing generic or brand name drugs becomes a different situation for physicians in hospitals, "where perhaps 80 percent or more of the bills are paid by third party payors who insist on cost reductions, sometimes dictating caps and tops they will pay for certain types of medications," said Basil Fritch, coordinator of pharmacy services at Ingalls Hospital in Harvey. "When our reimbursements get capped, we have to look for other ways to save money and stay profitable."

"It's getting so that the pinch on physicians' expenses and overhead costs is too high, since the reimbursement remains at a set level. The fact that we only pay for generics is forcing physicians to almost prescribe generics as a rule," said Fritch.

According to a Blue Cross/Blue Shield company spokesman, "Regardless of what drug is used, generic or brand name, it would be to the hospital's advantage to use generic drugs when appropriate."

"Whatever the hospital's charges are for room, board, general nursing care and prescription drugs, we will reimburse the hospital with an all inclusive rate, regardless of the type of drug used," he added.

A hospital pharmacy and therapeutic committee decides which drugs the hospital will purchase for patient use.

More layers

The process of prescribing drugs promises to become even more complex. Sales of generic drugs totalled $3.4 billion in 1988, making-up nearly one-third of all drugs made in the nation. "Because of the growth in the generic industry, many brand name drug manufacturers are taking part in a growing trend of producing non-branded products," said Mark Pilkington, Illinois Pharmacists Association.

"It's becoming more and more common, and if they don't own them outright or upfront, they own them as a subsidiary," said Fritch.

Meanwhile, generic drug industry officials share concern over the unfolding investigation into the generic drug approval process, fearing that as a result, public confidence in the industry will badly suffer.

"The investigation shakes up your confidence tremendously. Brand name companies are much more responsible to physicians and the public because we know what products they make. Therefore, they want to protect their name. Physicians don't know which generic company is making which drug. Before this investigation, we had no way of holding them accountable," said Dr. Hamid. ▲

Physicians comment on prescribing habits

Illinois Medicine *asked six physicians around the state to comment on their prescribing habits. They are Gary Carr, M.D., a physician in family practice in Lawrenceville; David Greathouse, D.O., an internist in Macomb; Imtiaz Hamid, M.D., a cardiologist in Harvey; David Steward, M.D., a general internist in Springfield; Gerald D. Suchomski, M.D., a family practice physician in Springfield; and Jay Walther, M.D., an internist in geriatrics in Flossmoor.*

Q: *When do you write "do not substitute" on the prescription?*

A: Dr. Carr: "Very rarely will I put 'do not substitute' on the prescription. "I prescribe generics all the time because it's less expensive for patients. However, I personally prefer brand names, especially in specific instances for less confusion. Elderly people taking multiple drugs have difficulty keeping them straight. A 70-year-old patient of mine was taking the same drug in a generic and brand name form at the same time because the pharmacist labelled it differently."

Dr. Greathouse: "I typically let patients decide whether they want to use generic or brand name drugs. My patients are very aware of the difference in generic and brand name drugs when it comes to price."



David Seward, M.D.

Dr. Hamid: "For me to write 'do not substitute,' the drug must be unique and have a very consistent bioavailability, [the amount and rate at which the drug enters the bloodstream], which most of them do. I have to give credit to most of the brand names because the bioavailability is so constant and I can rely on them quite a bit."

Since the early 70s, when some patients were prescribed the generic form of Lanoxin, used for heart disease, and got less or more of a dose than they should have because of its inconsistency, most physicians in general have been insistent that Lanoxin be prescribed because of its bioavailability. Year after year, Lanoxin's bioavailability has been relatively the same and the cost difference compared to the generic is not that great.

> *"A patient's subjective opinions of the drug carry a lot of weight in our decision to say 'do not substitute.'"*

I will also write 'do not substitute' when the patient tells me he's tried the generic, but doesn't feel it's as effective. A patient's subjective opinions of the drug carry a lot of weight in our decision to say 'do not substitute.' "

Dr. Steward: "Lanoxin, Phenytoin and L-Thyroxine are three medications that come to mind that I do not allow patients to substitute because of the bioavailability of these drugs."

Dr. Suchomski: "There are only a few medications that I write 'do not substitute' such as Macrodantin, an antibiotic used for urinary tract infections, and Lanoxin. The brand name is by far the most reliable for these drugs. In terms of the bioavailability of generic drugs, there is some variability from brand to brand.

Dr. Walther: "We trust when there is a generic drug available to us, it's going to be of like potency compared to the brand name. But this is only trust, because physicians deal mostly with the concept, name and action of a drug. For a long time, generic drugs were not accepted as being on par with brand names. However, as time increased, mainly because of the cost factor and action of the federal government, we're seeing more and more generic drug usage.

I do not substitute Synthroid, a thyroid drug. Studies have been done to show that it's just not as effective in generic form."

Q: *What influences your decision on whether to prescribe brand name or generic drugs?*

A: Dr. Carr: "Pharmaceutical reps have very little influence on what I will prescribe. Although I read the information they distribute, I'm always suspicious of it because I know they want to sell their product. I think pharmaceutical companies should just reduce the cost of medicine instead of mailing materials in fancy cartons. I get my information on certain drugs from periodicals, articles in medical magazines or newspapers."

Dr. Greathouse: "The only influence pharmaceutical reps have on my prescribing habits is the samples they leave which are helpful to the patient. Patients like to try the drug before they shell out money for the prescription. I would like to see more advertisements containing information from doctors themselves talking about their experiences with the drug."

Dr. Hamid: "I'm a creature of habit. I'm pretty well aware of what is occurring in research, investigations and protocols to the clinical practice and I usually follow the brand name drugs for several years before they are approved for general use. For example, there are three or four medications used for congestive heart failure and hypertension on the market right now. I will look at literature for effectiveness and what I see in different patients, and then I will choose which is most cost effective, rather than be influenced by information from pharmaceutical reps.

I cannot deny that samples have some influence in what I prescribe. At least four different companies make nitroglycerin, used for angina or congestive heart failure. If they rank pretty much the same in effectiveness, I will prescribe for the patient whatever samples I have."

Dr. Steward: "I suppose because pharmaceutical reps talk to me regularly, they have some influence on me, but I think the influence is probably pretty subtle. I try not to let what they say be the primary source I use to learn about drugs or to make decisions. I usually look to other sources to learn about drugs such as colleagues, specialists, textbooks or medical journals.

Advertisements are flashy Madison Avenue stuff, professionally prepared, and they do a good job. I don't think they're deceitful, but I think they tell me things that will be most convincing to me. They're designed to be as persuasive as they can. Even if physicians don't pay any attention to what the ad says, there are several larger, more prominent drug companies that advertise regularly and more frequently than do minor drug houses or less prominent ones, and that's got to be an influence on physicians—whether positive or negative. There's a cumulative effect of the same company advertising repeatedly over the years. Of course, we try not to let the ads influence our actions, but it's hard."

> *"I get my information on certain drugs from periodicals, articles in medical magazines or newspapers."*



David Greathouse, D.O.

Dr. Suchomski: "I meet individually with drug reps about twice a month. They're a good source of information in orienting me to new medications when their company releases a new drug. They're a good reminder of the wide choices sometimes. Premarin is a very common drug used as an estrogen replacement in women past menopause. When someone reminds you there is also Estrace available to do the same thing, you learn you're not as limited."

Sample medications are useful for two purposes. I occasionally have a patient who finds it difficult, because of financial reasons, to get a full prescription. I can help them out by giving them part of a prescription with samples. There are at least a dozen brand names of the non-steroidal medications for arthritis. The response from individual to individual using these medications is variable, and what works well for one person may not work as well for the next. After giving them several days worth of samples and a prescription, I can prescribe something else if the samples don't agree with them, without the patient spending significant amounts of money trying medication that doesn't work for them.

> *"A lot of my associates attend meetings and are paid sometimes $100 just to hear discussion about a particular drug."*



Gerald Suchomski, M.D.

To look at relatively unbiased reports and comparisons of drugs, there are reference textbooks and medical journals that look at drug safety profiles and cost comparisons. Those are very helpful in deciding what to prescribe."

Dr. Walther: "I think we have to be very careful because the forces acting upon physicians are really tremendous. A lot of my associates attend meetings and are paid sometimes $100 just to hear discussion about a particular drug. If you're not careful, that's going to really influence what drug you prescribe. The drug people that visit us are sometimes willing to give us dinner or lunch, and all it takes is for us to sit down and spend a few minutes listening to them. When I sit down and write the prescription out, they're betting that the information is going to be in my subconscious and that I'm going to prescribe their drug.

I don't see pharmaceutical reps. I think it's a really bad way to get information about a drug. Physicians are hearing a very biased opinion from somebody that only knows about the drugs they're selling.

Physicians also are the products of a lot of external pressure when it comes to advertising. Pharmaceutical companies, because of their degree of sophistication, can have a tremendous influence on us. The subliminal messages, costs and subtleness of their advertising are phenomenal.

Pharmaceutical companies spend much too much on advertising. I don't think we see very much honest advertising. No drug company wants to give an honest comparison of their drug. Physicians would be much better off if we saw advertising in our journals comparing the effectiveness of one drug of the same class versus another, instead of three pages of a beautifully laid out discussion on a particular drug. I would like to see an advertisement about drugs contain the mode of action, indications and side effects, a discussion of the cost, what advantages patients have using one drug compared to others in another class, comparison data to show that in good studies, the company's drug is more effective or has more efficacy than another particular drug. The savings that drug companies could make by giving us a more honest advertising campaign could be passed to patients and these tremendous drug costs might be reduced." ▲

New MD office lab rules set

by Karen Sandrick

RULES GOVERNING the operation of clinical laboratories in Illinois became effective July 1, 1989. They require all physicians who do office-based laboratory testing to register with the Illinois Department of Public Health (IDPH) by December 31, 1989. They also require physicians who perform certain types of tests to engage in proficiency testing and quality control and employ trained laboratory personnel.

The law creates five levels of regulation: registration class, class I, class II, class III and full licensure.

Most physicians will qualify for the lowest level of regulation and merely be required to register with the IDPH every year, but it is difficult to know for certain how physicians will be affected by the regulations. It is clear that any physician office lab accepting referrals will be regulated as a licensed laboratory.

"A fair number of physician labs are going to come in at the registration class, and all that will be required is filing an application. But there is no way of knowing exactly how many," says Rob Kane, administrative rules coordinator for IDPH.

"There have been estimates that 1500 to 7000 applications will come in, and we don't know who will be filing them or exactly what lab tests they are doing," Kane adds.

Covering a wide spectrum

David Nevalainen, Ph.D., from Abbott Laboratories, Morton Grove, points out that physician office laboratory testing covers a spectrum, "from using 10- to 15-year-old technology that requires multiple manual steps to using highly calibrated, and easy-to-use technology that practically does everything."

According to Richard Sassetti, M.D., chairman of the ISMS blood bank and laboratory services committee, "One of the biggest problems trying to anticipate the impact this law was going to have on physicians was the fact that it is very difficult to find out what the physicians in the state were doing. It seems clear that there is a majority of physicians who do tests from a relatively small menu, but the rest of them are doing all kinds of different things. Because there is no way of centrally collecting data, that is the group hardest to get a handle on. That is the group of physicians who are going to have to pay the most attention to the new regulations."

Requirements for five lab categories

The registration laboratory class must apply each year for registration with IDPH, but registration carries no fees nor any specific requirements for quality assurance activities. This category applies to physicians who perform a limited specific menu of tests and procedures, including urinalysis, test for occult blood, and blood cholesterol levels, in their offices. In addition, physicians who personally perform any tests, no matter how complex, for the express benefit of their patients, will qualify for the registration class. (For more detailed information on the regulations, see "Common Questions About the New Clinical Laboratory Regulations" below.)

Class I and II both require quality control activities, proficiency testing and trained personnel to perform tests. Class I applies to physician offices that perform certain types of simple tests, and class II applies to offices that conduct more complex testing procedures.

Defining the differences between "simple" and "complex"

The difference between simple and complex tests is where confusion is arising. The regulations provide a lengthy and complicated definition of simple tests. According to the regulations, a simple test is one whose results can be observed directly without manipulation or interpolation, calculated arithmetically, or determined by manufacturer-prepared reagents or solutions.

A test may also be considered simple for regulatory purposes depending on the methodology used, the degree of judgment involved, the difficulty of the calculations, and other factors.

The problem, says Dr. Sassetti, is that "some complex tests [may be] defined by the state as simple tests and fall in the lower, class I level, and some simple tests, by default, are considered complex tests and fall in the higher level of regulation." For example, he explains, "a simple, straight-forward positive or negative test such as a monocyte test [may] not meet the state's definition of a

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Common questions about the new clinical laboratory regulations

1. Who needs to register or apply for a permit or license for an office laboratory?

All physicians who perform laboratory procedures as part of their office practice.

2. When do I need to apply?

Application must be received by IDPH by December 31, 1989.

3. How do I apply?

Write to the Clinical Laboratory and Blood Bank Section, Illinois Department of Public Health, 2121 W. Taylor Street, Chicago, IL 60612, and ask for an application and a copy of the rules. Copies of the rules probably will not be available for three to four weeks. Physicians who wish to review the regulations sooner may visit their local public library and consult the July 14, 1989, issue of *Illinois Register.* The complete rules begin on page 11573.

4. What information do I need to provide?

On the application, you will need to provide the name and address of the laboratory, its hours of operation, the type of ownership and names of its owners, the type and names of the laboratory personnel employed, and the tests performed (their name, the instruments used, and the manufacturer of the instruments).

You will also need to decide in which regulatory classification your laboratory falls.

5. How can I decide which classification my laboratory meets?

Your laboratory will qualify for the registration class if its menu includes only the following tests and procedures:

- Urinalysis measured by dipstick or tablet
- Hematocrit by centrifugation
- Occult blood
- Urine pregnancy testing (semi-quantitative chorionic gonadotropin)
- Hemoglobin
- Red blood cell sickle cell screen using dithionite, sodium hydrosulfite
- Wet mounts for yeast or trichomonas
- Blood cholesterol
- Blood glucose
- Erythrocyte protoporphyrin using a hematofluorometer
- Screening for drug abuse using latex agglutination or another method that meets the definition of simple test
- Gonorrhea cultures for growth, oxidase and lactidase, Gram's stain
- Any other test personally performed and interpreted by the physician.

Your laboratory will be a class I permit laboratory if it performs, in

simple test, whereas an erythrocyte protoporphyrin level, which is a fairly sophisticated test, [may be] defined as simple because it is done on a machine."

Adding to the confusion, at least in the next few weeks, is the absence of a list of sample simple tests. IDPH is in the process of preparing such a list, but, says Kane, it will not be available until some time in September at the earliest.

Quality assurance goals

On the whole, however, the clinical laboratory regulations enforce quality assurance, "which hopefully will have a beneficial effect," says Dr. Sassetti, who added that, "Although it's been difficult to get a handle on [quality assurance efforts in physician office laboratories], my sense, and it is just a gut sense, is that human nature being what it is, quality control in office laboratories has probably been less than optimal."

Louis Owano, M.D., chairman of the department of pathology, Swedish American Hospital, Rockford, agrees. "I think that generally the controls that are used in physicians' laboratories are not as good as those used in other clinical laboratories like hospital laboratories. I don't think anyone expects physicians to have clinical laboratories of reference caliber, but they should at least be doing work that is of sufficient quality, and my major concern is that is not happening at the present time," he adds.

Quality assurance measures required by the regulations, i.e., proficiency testing and quality control, "are the sorts of things any good laboratory should be doing," says Dr. Owano. "Proficiency testing tests your accuracy by sending you unknown samples and seeing how close you come to correct results, which tells you that you are doing good work, that your results are accurate and reliable, and you're precise," he explains. "Quality control programs basically keep you on track, keep you doing accurate work, and they indicate how well your system is continuing on a day-to-day basis," he reports.

Both proficiency testing and quality control are required of class I and class II laboratories because "neither is foolproof," says Kane. But there is some flexibility in the way physicians may conduct these activities, Dr. Nevalainen notes. "There is an emphasis on utilizing the manufacturer's recommendations for quality control, the frequency of calibration of instruments, etc., which takes the regulations away from a straightjacket, uniform approach of doing quality control the same way no matter what test or instrument is involved," Dr. Nevalainen believes.

The bottom line? "There is no question that some folks will have to devote some resources and time and effort to get their labs in compliance," says Dr. Nevalainen. "There will be more paperwork," adds Dr. Owano. And, until it is clear how the regulations will be applied, there may be confusion. ISMS asks that all members who feel an educational program on the new clinical laboratory regulations would be worthwhile to contact the Division of Educational and Medical Services, ISMS, 20 N. Michigan Avenue, Chicago, IL 60602, (312) 782-1654, ext. 1146. ▲

addition to the tests listed for the registration class:

- Simple tests, which have these characteristics—interpretation of visual signal by pattern recognition, color definition or numeric information using an established control example which can be observed directly by the operator and requires no manipulation or interpolation by the operator to derive a result; or use of simple addition, subtraction, multiplication, or division; or the use of manufacturer-prepared reagents or solutions which are combined without requiring numerous specific calibrated volume measurements or sequential applications; or are defined by the director of IDPH as simple based on several factors.

Your laboratory will be a class II permit laboratory if it performs the tests listed for the registered class and class I as well as complex tests.

The class III permit applies to for-profit health screening laboratories only. Physician office labs are not likely to fall into this category.

Your laboratory will require a full license if it performs tests for other physicians' practices.

6. What requirements will I have to meet?

You will need only to register each year with IDPH if your laboratory is in the registration class.

If your laboratory is in class I, you will have to:

- Have a laboratory director;
- Have a laboratory assistant (this can be any person trained to do lab tests in the physician's office);
- Engage in proficiency testing for every test your lab performs;
- Have established quality control procedures.

If your laboratory is in class II, you will have to:

- Have a laboratory director;
- Hire a medical technician or medical technologist;
- Engage in proficiency testing for every test performed;
- Have established quality control procedures;
- Undergo an inspection by IDPH every two and a half years.

If your laboratory is licensed, you will have to:

- Have a director;
- Have a general supervisor present full time;
- Engage in proficiency testing for every test performed;
- Have established quality control procedures;
- Undergo an inspection by IDPH every year.

7. What fees will I have to pay?

- None for registered laboratories;
- $50 initially and $25 every year for class I laboratories;
- $100 initially and $50 each year for class II laboratories;
- $300 initially and $150 each year for licensed laboratories.

8. Will I need to hire new personnel?

A grandfathering provision gives you three years to find and hire staff if you do not currently employ any. It may also give you sufficient time to have your present staff trained to meet this requirement. ▲

AIDS Conference Scheduled

Physicians, other health care providers and educators interested in HIV and AIDS among adolescents will have a chance to learn and network at an Adolescents and AIDS conference in Chicago on Friday, September 22 at Rush-Presbyterian-St. Luke's Medical Center, 1725 W. Harrison St., Chicago.

The conference, from 8:30 a.m. to 4 p.m., is sponsored by the Society for Adolescent Medicine, the National Institute on Drug Abuse, the National Institute of Child Health and Human Development and the National Institute of Mental Health.

The keynote speaker is Karen Hein, M.D., an adolescent medicine specialist at the Albert Einstein College of Medicine in New York.

Other general sessions include: Research in Adolescent AIDS, Status of AIDS in Chicago, Medical Evaluation and Staging of HIV, and Legal Aspects of AIDS. Participants will be able to choose two of four workshops, including an ISMS/AMA presentation: "Patient and Professional Education."

Registration is $25 and includes lunch. An additional $25 is required for physicians who wish to receive CME credit.

For more information, write or call Rush-Presbyterian-St. Luke's Medical Center at 312/942-3034.

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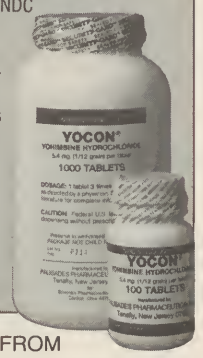
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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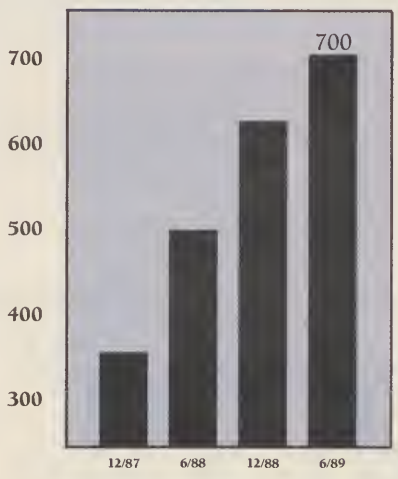
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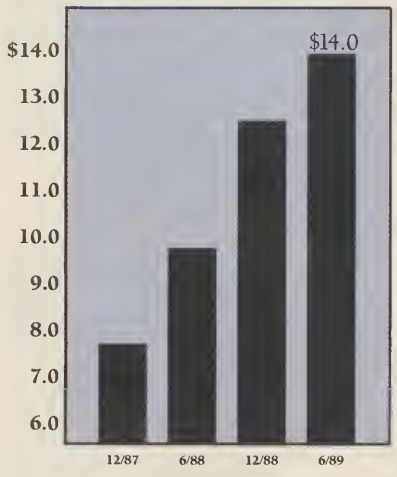
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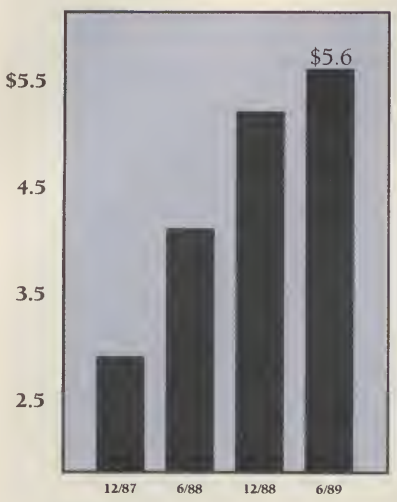
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(continued from page 2)

"If the physician on the scene is the patient's own personal physician he obviously knows the patient, has a history and he's working as [the patient's personal physician]. Other than that, as far as I'm concerned, the paramedic is in charge. A physician may come up and offer assistance and if he's asked to do something, he should do it. But I don't see how he can really be in charge unless he clearly states that he will take full responsibility for the total care of the patient all the way to the hospital," said Dr. Zydlo, outlining his protocol. He said that while physicians are not used to working in streets, apartments, subways, grocery stores or other unusual places and around crowds, paramedics are.

"If they're [paramedics] called they follow protocol. How can some itinerant physician just come up and say 'I'm in charge here now, but I'm not going to take responsibility five minutes from now'? It would be disruptive. I mean, a doctor wouldn't want a doctor doing that; there's no continuity of care. So, in general, we tell [paramedics] if physicians come on the scene and they're not the patient's own doctor and they wish to assist, ask them to do something like start an IV. It's really a mutual understanding. If each one looks at the other's role there should never be a 'conflict' because there is none. The goal is good patient care," Dr. Zydlo explained.

He added that most doctors who do stop to assist at emergencies are "really reasonable." "They'll say 'Can I help? What do you want me to do?' Now, that's the proper approach."

Dr. Zydlo said he would not want to see paramedic protocols standardized by legislation because he feels emergency medical systems should have the flexibility to decide on protocols that are right for their area's particular unique circumstances.

Ron Lee, M.D., who is the PMD at Loyola University Medical Center, a level I trauma center, emphasized that paramedics and the physicians with whom they are in contact are specially trained to handle emergency situations, whereas many other physicians who specialize in fields other than emergency medicine are not.

"Clearly, pre-hospital medicine is a defined field and some physicians who may come upon the scene are not really prepared to handle the type of medicine or the type of care the patient needs because it's foreign to them. You know, it's very difficult to render care in the back of an ambulance and at times physicians are, although willing to help, to some degree not always familiar with the procedures, protocol and equipment," Dr. Lee explained.

Like Dr. Zydlo, Dr. Lee said that if the physician who stops at the emergency scene is the patient's physician of record, the paramedics adhere to all his suggestions unless they feel for some reason that the treatment being recommended is inappropriate. "If that were the case, they're instructed to contact us immediately before they administer something they thought was not appropriate," he said.

Dr. Lee said that while having physicians stop at emergencies and offer help is "not an everyday occurrence," it is not uncommon and most of those who do get involved are cooperative and genuinely interested in helping. He said what conflicts do occur are often the result of a clash of personalities between the paramedic and the physician or involve cases where the appropriate treatment is not always immediately clear.

He said he feels it would be a good idea to standardize the procedure in these situations so that both paramedics and physicians throughout the state would be aware of exactly how to handle things.

"I think it makes sense to make it standardized so that physicians in southern Illinois and northern Illinois would understand exactly what is expected of them if they come upon a scene and wish to assist. They would understand that it would probably be appropriate for them to continue providing care enroute to the hospital. Some systems require it, some do not. I think . . . that it is appropriate to standardize how the interaction should occur," said Dr. Lee.

"I think what we want to do overall is to encourage physicians to participate. What we would like is for them to become knowledgeable about the system," he added.

Alan Roman, M.D., a trauma surgeon, said he feels that paramedics and physicians should work together when both are at an emergency scene and should use common sense in doing so.

He said in the event there is a physician on hand who is experienced in treating emergency cases, the paramedics should, as a matter of common sense, yield medical control of the situation to him. At the same time, he said, a physician who has had little experience in such cases should not attempt to take control from paramedics who are trained and experienced. He said he does not favor legislation to standardize paramedic protocols.

"You can't legislate common sense and you can't legislate good judgment. If common sense and good judgment prevail, the paramedic and the physician should work together very closely. If guidelines get too dogmatic you're liable to legislate yourself into a situation where dogmatism prevails over common sense and the patient may not be the benefactor," said Dr. Roman.

He added that while he does not train paramedics and emergency-medical technicians (EMTs), he does have occasion to work closely with them and feels that they are, for the most part, "conscientious and hard working."

"I have nothing but respect for them," he added.

John Holland, M.D., PMD for the Springfield Mobile Intensive Care System, a post he has held since 1976, said under his protocols, if a doctor positively identifies himself as a physician at an emergency scene, he or she is allowed to take full charge, provided it is also agreed that the physician will take full responsibility for the patient's treatment.

"We allow them to talk over the radio with our managing doctor and he will tell them, 'Yes, fine doctor, you can take over. We'll tell our people to take orders from you but if you do start the treatment, we ask that you ride in the ambulance to the emergency room with the patient and the paramedics and assume full responsibility; as soon as the patient arrives here we'll take over.' This is exactly what we've been doing since 1977 and we've had few takers," Dr. Holland explained, adding that the protocols call for the physician to agree to this over the radio so that there is a taped record of the agreement.

"Most of the time most of the doctors in our area are very happy to let the paramedics do it," Dr. Holland said, adding, "We teach our paramedics to respect duly identified physicians."

Virginia Kennedy, executive director of the Illinois chapter of the American College of Emergency Physicians, stressed the fact that paramedics are in contact with physicians who specialize in emergency medicine.

"The thing that's really important to understand is that the paramedic is functioning under the direction of his PMD who's a physician and is probably directly on-line with him getting information as he's working on a victim or patient, so it's not that they're totally independent," said Kennedy.

One thing that those interviewed agreed on is that a physician who may find him or herself in the role of a good samaritan should always carry the state-issued identification card that clearly shows them to be a licensed physician in the state of Illinois. Since protocols vary throughout the state, it would also seem a good idea for physicians to familiarize themselves with paramedic protocols in the area in which they live and practice. ▲

Blood supply still low in Illinois

CHICAGO's blood supply, particularly for Types O and B, is still on the critical list, according to LifeSource, a major supplier for the Chicago area. Despite a temporary surge in blood donations in early August, the blood supply again fell to very low levels later that month. A LifeSource blood distribution center spokesman estimated it will take two months of "generous giving" to replenish the supply and bring Chicago area hospitals back to a comfortable supply level.

Elsewhere in the state, the blood shortage is not as severe. American Red Cross Blood Service, in Galesburg, serving Illinois, Iowa and parts of Missouri, had a "bad month" in July, but collections have returned to normal levels of 2,000 units monthly, according to Ronald Schulte, executive director.

Carol Talacki, M.D., medical director of the Heart of Illinois Center, serving Peoria and other central and northern Illinois areas, termed the situation "satisfactory," after an "off and on" shortage during the summer.

Champaign County Blood Center, serving hospitals in Champaign, Chicago and out of state, had "seasonal lows" this summer, but is not facing any shortages or outages. According to Bill Treadway, executive director, the center depends heavily on college student donors, and collections are rising again since school resumed. ▲

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Chicago and "collar counties" step up measles control efforts

CHICAGO and Du Page County, Illinois' two hardest hit measles outbreak sections, continue to step up efforts to control the areas' steadily climbing number of measles cases.

Since the outbreak began in February, 1989, the Chicago Department of Health confirmed 1,019 measles cases in Chicago as of August 21. The number of measles cases reported in Du Page County totalled 280 as of August 22.

Meanwhile, other counties bordering Chicago are experiencing a decrease in the number of confirmed measles cases since the spring outbreaks.

At the Du Page County Health Department, where the demand for measles immunization is high and the vaccine supply low, officials are referring individuals to private physicians until more measles vaccine can be obtained from the state.

"All four of our county's service centers are booked solid until October 3. All measles immunizations are done by appointment." But I had to tell the centers to stop making appointments because we have to reassess our situation," said Ann Larson, Du Page County Health Department epidemiologist.

Nineteen to 32-year-old individuals made up more than half of Du Page's cases. Pre-school unimmunized children accounted for the remainder.

In suburban Cook County, the epidemic hit pre-schoolers and individuals over six years old the hardest. "Since the August 2 report of 150 measles cases in suburban Cook County, we've confirmed 30 additional cases," said Addie Reninger, director of community health at Cook County Department of Public Health (CCDPH). CCDPH immunized 10,375 residents from August 4 to 18 in special immunization clinics.

The Kane County Health Department (KCHD) reported a total of 95 measles cases within the county since the outbreak began. "Most of them occurred in April and May. It's been over four weeks since the onset of the last reported isolated case," according to Lori Sarro, KCHD communicable disease coordinator.

As of August 22, McHenry County Health Department (MCHD) officials reported no new measles cases within the county since the end of May. Most of the county's 81 cases also occurred during the spring and affected primarily high school age individuals.

During an August 9 clinic, MCHD used up all 60 doses of the measles, mumps and rubella vaccine on 15-month-old and pre-school age children only. "Because our next shipment of measles vaccine from the Illinois Department of Public Health didn't arrive until after our clinic, we were forced to borrow vaccine from area physicians," said Nancy Bergquist, MCHD communicable disease coordinator.

Will County experienced 57 measles cases this year. Nearly half of those cases occurred after May 1, primarily in the one to two-year-old age group. As of August 22, there have been only four confirmed measles cases.

Measles Cases since February 1989

Chicago:	**1,019**
Surburban Cook:	**180**
DuPage County:	**280**
Kane County:	**95**
McHenry County:	**81**
Will County:	**57**
Lake County:	**20**

(as of August 22, 1989)

"Will County Department of Health (WCHD) is offering only the measles vaccine to six to 15-month-old infants in a small targeted area in Joliet where we have seen cases," says Elizabeth Law, WCHD nursing supervisor. "For other parts of Will County, we have the regularly scheduled immunization clinics that occur throughout the year, except with extended hours. Vaccine is available, but it's tight here," added Gilbert Wold, director of the disease control division.

As of August 22, Lake County reported a total of 20 measles cases during the 1989 outbreak. Most occurred at the end of March and beginning of April in primarily high school and college age individuals. The Lake County Health Department confirmed three measles cases for the month of May, none for June, two for July and as of August 22, only one case for the month of August. ▲

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UI/Reese

(continued from page 1)

versity of Chicago, whose own affiliation with Reese was terminated by the UI/Reese proposal. In addition, Mercy is said to be seeking to affiliate with several institutions, already having achieved an "enhanced" relationship with Loyola University. Finally, Ravenswood is having discussions with Rush-Presbyterian-St. Luke's Hospital and Medical Center.

The implication of Stukel's report is that the impact of the university losing these three affiliations could be serious. For example, Stukel cited one set of statistics showing that all five current affiliate institutions provide a total of 2,376 beds—or, as one UI trustee called them, "potential teaching opportunities"—for UI students. Losing the three affiliations would mean the loss of 925 of those beds, or 39 per cent. However, executing a new affiliation agreement with Michael Reese would restore 418 beds, bringing the total to 1,869, only a 22 per cent loss.

Reese affiliation still possible

Stukel's committee seems to have decided that an affiliation with Michael Reese is not out of the question. "There was never an objection to an affiliation with Michael Reese, only the one that was proposed," said former UI medical staff president John L. Skosey, M.D., and a member of the committee. Dr. Skosey said the objection centered on giving Michael Reese inordinate control of academic programs.

For his part, Michael Reese president Henry Nadler, M.D., told the UI board that he was committed to working out a mutually beneficial agreement if the university wants to. However, Dr. Nadler said that he needed the issue resolved within the month. He also said that the current disputes regarding the "leadership of the College of Medicine" must be made "unambiguous."

At issue are several combined Michael Reese service chief/UI academic department head appointments approved by the UI board of trustees last April in accordance with the former agreement. Six of the appointments are currently held by Michael Reese-based physicians, at least three of which seem to be unacceptable to segments of the faculty. The Stukel committee has so far addressed this issue only generally, saying that the university hospital must be the college's primary teaching hospital, and that College of Medicine department heads must also be university hospital-based service chiefs.

Following the August 10 special meeting, the Stukel committee reconvened to consider drafts of a master affiliation agreement to be utilized whenever the university affiliates with another institution, as well as to create a new draft subordinate agreement specifically geared to Michael Reese.

Upon approval by the Stukel committee and Michael Reese, the agreements are to be presented to the trustees at their regularly scheduled September 14 meeting.

Other committee conclusions

Stukel's report also painted a grim financial picture that pins the hospital's future viability to renewal next year of a "one-time" $25 million additional appropriation, continuance of a significantly improved Medicaid rate negotiated for the coming year, and to a significantly expanded daily census.

The Illinois General Assembly appropriated the additional money after refusing to authorize the university's plan to make Michael Reese Hospital and Medical Center the university's primary teaching hospital, while leasing the university hospital to Cook County Hospital. When announced last December, the proposal precipitated a bitter, six month controversy that divided the faculty, pitted several surrounding community organizations against the university, decimated the faculty and hospital staff, and finally resulted in the resignation of College of Medicine Dean Phillip M. Forman effective next year. ▲

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Illinois Medicine

September 15, 1989 ILLINOIS STATE MEDICAL SOCIETY

Pro-Lifers oppose Ragsdale settlement talks on abortion

by Kevin O'Brien

REPORTS OF a possible settlement of the potentially landmark Illinois abortion case, *Turnock* v. *Ragsdale,* caused consternation among pro-life advocates, as well as questions about whether a settlement would even be possible.

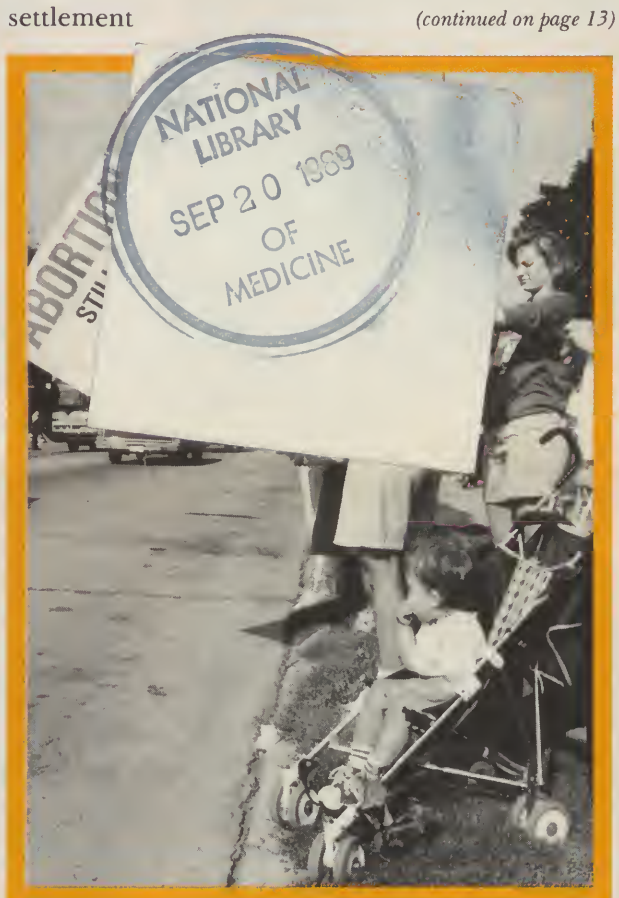
"I am very leery of a settlement because the General Assembly, which represents the people, is not involved in this," said Ralph Rivera, chairman of the Illinois Pro-Life Coalition.

"We're opposed to a settlement," said Illinois Right-to-Life Committee executive director Richard O'Connor. "We'd like to see the thing continue its course and be decided by the Supreme Court one way or the other because any deal that's made between Turnock and Ragsdale would simply mean a compromise in the quality of care that women are going to receive."

Representatives of both state offices confirmed that Deputy Atty. Gen. Michael Hayes approached Illinois Department of Public Health (IDPH) Director Bernard Turnock, M.D., about settling *Turnock* v. *Ragsdale* before it can be heard by the U.S. Supreme Court this fall.

Because the case deals with the state's authority to regulate first trimester abortions, the case could be the one that overturns *Roe* v. *Wade,*

(continued on page 13)



Abortion activists in Rockford demonstrate at rally.

Photo: Jon McGinty



Photos: Tim Boyle

Experts speak out at a public hearing on the state's perinatal network delivery system, (L to R) Harold Jensen, M.D., Ingalls Memorial Hospital, Udochukwu Asonye, M.D., Neonatal and Pediatric Services, Phyllis Jones, Perinatal Association of Illinois, and Carol Havel, Morris Hospital.

Revised perinatal network proposed

WHILE THE Illinois Department of Public Health (IDPH) is aiming for January 1, 1990 adoption of a proposed revision to the state's regional perinatal care network delivery system, perinatal experts voiced deep concern about the proposals at two recent public hearings.

More than 80 perinatal health care professionals attended the hearings in Springfield and Naperville, August 28 and 31.

Guidelines regulating the state's perinatal program have existed since 1981. Under the system, hospitals are categorized according to the extent of obstetrical and perinatal services they offer, from a Level 1 designation for basic OB services, to Level 3 for the most comprehensive tertiary care for newborns. Level 3 facilities are called perinatal centers.

"The proposed revisions indicate far more detail in the standards for perinatal facilities," according to Robert Sabich, executive director of IDPH's perinatal program. "Because there's a greater delineation for the kinds of conditions, both obstetrical and newborn, some hospitals will have to decide whether appropriate consultation, transfer or transport to a perinatal center should occur. There will be a stronger focus on the letters of agreement between perinatal facilities and their perinatal center," he added.

Rural Illinois

Physicians fear adoption of the proposed rules will most adversely affect Illinois' rural areas by adding to an already existing problem of patients sometimes traveling long distances or to other states for delivery because of the lack of OB/GYN physicians.

In southern Illinois, five Level 1 hospitals feed patients into Carbondale Memorial Hospital, the only

(continued on page 14)

Part two of a series

MDs, PRO officials debate quality review process

Quality health care, much like beauty, can be in the eye of the beholder. And Medicare's Illinois peer review organization (PRO) reigns as the "beholder"—and arbiter—of quality care for the almost 1.5 million Medicare-dependent seniors in Illinois. This week Illinois Medicine *looks at the Illinois PRO's quality review process, and the ongoing debate on its effectiveness.*

"ASSURING BOTH Medicare beneficiaries and physicians in general that medicine practiced in Illinois is of high quality" is the rationale behind Medicare's quality review program, says Steven White, M.D., who heads up the medical quality review committee for Crescent Counties Foundation for Medical Care (CCFMC)—the Illinois PRO designated by Medicare.

Dr. White, a pulmonary, critical care and internal medicine specialist at University of Chicago Hospitals, thinks the PRO's quality review system works to defy the mythology that "physicians won't expose problems when they exist." His personal goal is to "demonstrate to all concerned that physicians *do* care, that when we do identify problems, we can do something about it." That's how he explains his involvement with such an unpopular program to colleagues around the state.

The Medical Environment

A periodic observation on issues and trends affecting modern medical practice, and the challenges they present.

But Robert Vautrain, M.D., of Springfield views PRO quality assurance differently. "Generally speaking, when Medicare says 'quality care,' you can read 'cost containment.' That's what they're interested in."

Adds Chicago internist Joseph Murphy, M.D., "Doctors were foolhardy when we complained about Medicare's attempts to cut costs. We said, 'We want you to pay attention to quality instead.' Then Medicare

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New temporary licensing procedure gets mixed reviews

by Franklin J. Kourt

A PROMISE that completed applications submitted by May 1 would result in the issuance of temporary licenses to practice medicine in residency programs by July 1 this year was kept, according to Pat Eubanks, assistant section manager, health services section of the Illinois Department of Professional Regulation (IDPR), but reactions to the state's licensing procedure by residency directors around the state were mixed.

"It went well. By mid-June we were doing overnight [computer] runs instead of the normal twice a week runs so that licenses were being issued on a daily basis," Eubanks said, adding at that time the department also started faxing licenses to residency directors to ensure timely issuance.

Although she said the department still received numerous applications after the May 1 deadline, she felt that this year things improved. "The problem will never go away, but I will say it was better," she said, explaining there are numerous reasons would-be residency program participants missed the 60 day deadline, such as finding out they did not qualify for the residency program they were hoping for and having to reapply.

1300 licenses issued

Eubanks said over 1,300 temporary licenses were issued by the department this year, and only 49 remained to be processed as of August 28. "The crunch is over," she said. The department also processed over 200 requests for transfers from one residency program to another and those too were taken care of by July 1 if the necessary paperwork was in to the department by May 1, she said.

According to Eubanks, IDPR is constantly evaluating the process to make issuance of temporary licenses as efficient as possible for all concerned. For example, she said, the verification of education form was a problem for some foreign-educated applicants, so it has been revised. An even greater number of forms are now being ordered for next year.

A change in the law this year mandated that those people who graduated from medical school prior to 1985, never received a license in any jurisdiction and who applied for a license this year, had to have clinical skills evaluated prior to issuance of a license. Eubanks said this is intended to ensure doctors' skills are up to date. As of January 1, 1990 the law will require all those who have been out of medical school for at least five years and never licensed to have their skills evaluated before being issued a temporary license.

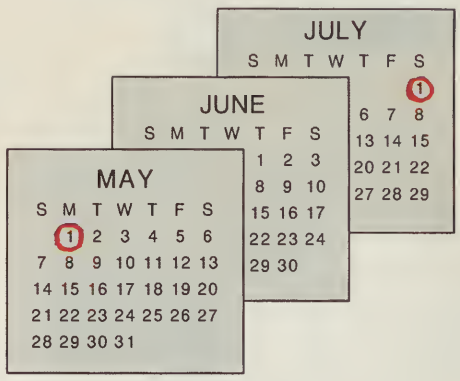
Smooth process overall; a few problems persist

Bruce Becker, M.D., chairman and program director of the department of family practice at St. Mary of Nazareth Hospital in Chicago, agreed that this year's issuance of temporary licenses went better than last, but added that there are still problems. He said that of eight first year residents who had applied to his program, five were delayed for a period of nine days to a month in starting and one resident who did not make the 60 day deadline would not have a license until mid-September.

"I was happier [than last year] because most of the men and women got on board within a month, but still it was a month," Dr. Becker said, referring *Illinois Medicine* to Irene Thibault, his coordinator of medical education for details.

Thibault said the problem was slow response by the state due to what it considered incomplete applications, and inconsistencies in requirements. She said her department would submit what it thought were completed applications, only to find out from two to five weeks later that additional material was needed, resulting in a slowdown of the process. She agreed that things were better than last year, but felt future improvements are needed.

Peter Fried, M.D., residency program director and chairman of the medical education committee at Christ Hospital and Medical Center in Chicago, said he has had positive experiences with the state for about three years.



"All of our residents had their temporary licenses by June 26, so we really didn't have any problems. I have to admit that over the past two or three years I thought they [the state] have been doing really quite an exceptional job. We've had no problem at all with them in our department," said Dr. Fried.

He said part of this success is due to his department's cooperation in expediting the process by having all necessary materials ready for applicants, and by the hospital collating all materials for the applicants. "We don't send the application into the state until it's completed here . . so we know when it goes to the state it's complete," he said.

Alan Birtch, M.D., director of the general surgery residency program at Southern Illinois University in Springfield, concurred with Dr. Fried, saying that he had no problem whatever this year with getting temporary licenses for the seven residents in his program, and added that in his experience the system has worked well over the years.

"When things work well from year to year it's hard to say whether it's better or not," said Dr. Birtch.

Quincy MD reports snag

Things did not work out nearly so well for Terry G. Arnold, M.D., director of the Quincy Family Practice Center in Quincy.

"That is a sore subject. We have had problems," said Dr. Arnold, explaining that he has one person who applied for residency on May 2 who is still waiting for a decision by the state board on whether he will be granted a temporary license.

"There have been all kinds of problems, in terms of trying to determine whether the appropriate documents are there or not. He's been going around in circles and now they're saying that the board will have to review [the application] at its next meeting," said Dr. Arnold. "This [applicant] has been put through quite a bit and I think unnecessarily so. They could have determined initially whether he is licensable or not."

"He [the applicant] has had all the materials available and they'll say 'well, there's something else missing.' I've used the "hot line" [to talk to the state] and get a different answer than when he calls. This is the worst situation we've had in a number of years," Dr. Arnold said, adding that he's not sure the department processing applications knows "the letter of the law." ▲

Governor signs malpractice affidavit law

REQUIREMENTS ARE strengthened for physicians certifying merit prior to the filing of malpractice lawsuits, under a bill signed into law by Governor James R. Thompson September 1. The measure was previously approved by state lawmakers during the recent Springfield legislative session, where the Illinois State Medical Society (ISMS) worked closely with the bill's sponsors, State Rep. John Cullerton (D-Chicago) and State Sen. Howard Carroll (D-Chicago).

Key elements of the new statute include the requirement that physicians certifying that there are meritorious grounds for filing the action must have either practiced or taught within six years "in the same area of health care or medicine that is at issue in the particular action," and that the certifying physician "is qualified by experience or demonstrated competence in the subject of the case."

The legislation was initiated in response to an earlier Illinois court decision removing the need for a specialist to certify that meritorious grounds exist for filing the action, on grounds that there is no specialty licensing in Illinois.

Robert C. Hamilton, M.D., chairman of the Illinois State Medical Insurance Services (ISMIS) board of directors commented, "Since one of the components of the 1985 tort reform was the certificate of merit, this has certainly cut down on the number of cases filed, and has been very significant in helping to stabilize our rates. The fact that now a physician must be in the same area of medicine will probably have a positive effect on the more complex cases, and simply reinforces the need for such prefiling screening."

However, judicial action on this same tort reform in the first district appellate court has ruled unconstitutional the entire certificate of merit requirement. The court's decision differed from the opinions of the other three state appellate courts, keeping the certificate of merit requirement in effect outside Cook County. In late July, the Illinois Supreme Court granted petitions for appeal, and ISMS plans to file an amicus brief in the case. ▲

Physician Facts

HMO 1988 Average Monthly Premiums

(For Family Coverage)

Alabama	$228.81	Kentucky	$236.99	North Dakota	$250.24
Arizona	250.44	Louisiana	235.46	Ohio	251.35
Arkansas	228.55	Maine	248.33	Oklahoma	253.17
California	251.76	Maryland	255.38	Oregon	213.18
Colorado	228.90	Massachusetts	292.27	Pennsylvania	221.64
Connecticut	282.40	Michigan	243.91	Rhode Island	242.50
Delaware	229.88	Minnesota	229.62	South Carolina	186.67
Dist. of Columbia	236.32	Missouri	250.50	South Dakota	280.54
Florida	220.67	Montana	205.00	Tennessee	245.38
Georgia	237.86	Nebraska	253.75	Texas	254.40
Hawaii	221.01	Nevada	300.00	Utah	278.40
Idaho	227.50	New Hampshire	281.50	Vermont	206.00
Illinois	227.20	New Jersey	222.79	Virginia	282.89
Indiana	237.21	New Mexico	272.27	Washington	242.99
Iowa	215.25	New York	216.21	Wisconsin	253.51
Kansas	248.80	North Carolina	235.63	Wyoming	220.00

TOTAL U.S. $242.49

Source of Data: SMG Marketing Group, Inc., 1989.

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Public Aid boosts lab fees to physicians for some services

PHYSICIANS CAN expect to receive a 16.5 percent fee increase for certain clinical pathology and surgical pathology procedures, as part of the Illinois Department of Public Aid (IDPA) reimbursement boosts provided in its new 1990 budget, effective September 1, 1989. In addition, all other laboratory services will receive a five percent reimbursement increase, under the new budget for this fiscal year.

In all public aid billings, physicians should continue to bill their normal charge, since IDPA pays either its fee schedule or the physician's actual charge, whichever amount is lower, according to an IDPA spokesperson. Since IDPA has recently raised fees, physicians who have been charging only what they expect IDPA to pay may not receive the new increases.

As previously reported in *Illinois Medicine* August 4, physicians received a 42.3 percent reimbursement increase for public aid patients' office visits, as well as significant boosts for prenatal and obstetrical care and "Healthy Kids" visits. Surgipak reimbursement to physicians also increased 20 percent, and all services not otherwise affected received a 16.5 percent across-the-board increase.

The new increases for laboratory services help strengthen the public aid program, according to Eugene P. Johnson, M.D., Illinois State Medical Society president.

"All of these important steps help remove serious barriers to care for public aid patients, an issue which deserves to be a top priority. For too long, the state's deteriorating fee schedule threatened to prevent the health needs of the poor from being adequately met, and discouraged physicians from participating in the public aid system.

"Now, the state has demonstrated it recognized the need for improvement, and the situation is more optimistic for both physicians and patients, despite the fact that continuing problems with the public aid system remain." ▲

These lab fees to MDs increased 16.5 percent Sept. 1:

CPT CODE	DESCRIPTION
80500	Clinical pathology consultation; limited, without review of patient's history and medical records
80502	Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records
85095	Bone marrow smear and/or cell block; aspiration only
85100	aspiration, staining and interpretation
85101	aspiration and staining only
85102	Bone marrow needle biopsy
85103	staining and interpretation
85105	interpretation only
88300	Surgical pathology, gross examination only
88302	Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes
88304	Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen
88305	single complicated or multiple uncomplicated specimen(s) without complex dissection
88307	single complicated specimen requiring complex dissection or multiple complicated specimens
88309	complex diagnostic problem with or without extensive dissection
88329	Consultation during surgery;
88331	with frozen section(s), single specimen
88332	each additional tissue block with frozen section(s)

IDPA does not currently reimburse for anatomical pathology (autopsy) codes. All other pathology procedure codes in the 80000 series received a five percent increase.

Retirement funds now protected

GOVERNOR THOMPSON signed into law August 30 a bill aimed at protecting physicians'—and citizens' retirement funds from being wiped out by a verdict.

The governor's signature on S.B. 162, which protects Illinois residents', including physicians' pension assets from creditors in bankruptcy, is a big victory for the Illinois State Medical Society (ISMS) which supported the bill, said Saul Morse, ISMS general counsel. "We have for several years been trying to protect retirement assets from principally malpractice plaintiffs. I think it's inappropriate that one malpractice judgment can destroy someone's whole life."

Chief sponsors of S.B. 162 were Senator Greg Zito (D-Melrose Park), and Rep. Sam Wolf (D-Granite City).

The governor has until September 24 to take action on a similar bill that passed the General Assembly. Under this version (H.B. 247), assets of physicians who "control" more than half of the employer, essentially those practicing individually or in a two physician partnership would not be protected. This would also apply to assets of small businesses such as insurance agents, real estate salespersons, podiatrists and lawyers.

H.B. 247, introduced by the Illinois State Bar Association, provided protection for all pension assets as it passed the House. However, the Senate amended the bill to apply only to pension plans of larger employers. ▲

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

CROSSOVER UPDATE

The following billing information is to further educate our physicians who bill electronically.

A. New Group Numbers Added To Crossover

The following group numbers have been added to the automatic crossover program of electronically submitted Medicare Part B claims to the Blue Shield claims processing systems.

069901	069906	069911	069916	069921
069902	069907	069912	069917	
069903	069908	069913	069918	
069904	069909	069914	069919	
069905	069910	069915	069920	

NOTE: In a letter dated November 4, 1988, Illinois EMC submitters were notified of other group numbers that crossover automatically. If you desire another copy of that letter, please call (312) 938-7697. **One of our major groups that crosses over is the Federal Employee Program (FEP). FEP members have to notify FEP that they wish to participate in the crossover program.**

B. Message On Beneficiary Explanation of Benefits and Provider Summary

The following messages indicating that the Medicare "B" claim has been crossed over to Blue Shield appear on the beneficiary's Explanation of Benefits (EOB) and the Provider Claim Summary.

BENEFICIARY MESSAGE

This information is being sent to your supplemental carrier for further consideration.

PROVIDER SUMMARY

This claim forwarded to the patient's complementary insurer.

Blue Cross and Blue Shield of Illinois requests that you (the Electronic Media Claim submitter) do not submit paper claims as the claim has already been crossed over for consideration.

Crossover was instituted to make your billing easier. If you have a Blue Shield provider number and wish to participate in crossover, please call (312) 938-7697.

(This report is a service to the physicians of Illinois)
9/15/89

Editorials

Continuing the pursuit of excellence

Continuing medical education is becoming more than a traditional way for physicians to hone their skills and keep up with scientific advances. As medical professionals—and outside critics—try increasingly to assess and quantify health care quality and competence, physicians' documented participation in CME programs is likely to count heavily as a criterion of measurement.

Most physicians need no mandate or spur to seek continuing medical education. Throughout their professional careers, and often during retirement, doctors voluntarily attend numerous formal and informal educational forums, many sponsored statewide through ISMS support. Medical professionals choose these educational opportunities regardless of whether documented credit for attendance is awarded. Their impetus is the opportunity for helpful new knowledge, self-improvement and the recognition that competency and quality are inseparably linked with never-ending learning. Similar motivational standards should be applied to anyone wanting professional rank—in health care or elsewhere.

Taking the membership's pulse

The 1989-90 ISMS President's Tour itinerary and an Illinois roadmap have much in common—both are designed to take the bearer to the most important destinations, and to effectively create open access and communication between communities, regardless of size. These are the admirable goals set by ISMS' president, Eugene P. Johnson, M.D., as he participates in a year-long, energetic dialog with our membership statewide.

This year's tour started earlier, and will visit more counties than before, a clear message that organized medicine's leadership cares about every member's concerns, and that we're working intensively to help address them. The tour also creates an excellent milieu for discussing the serious challenges facing physicians and patients, and the importance of every individual physician's participation in the political process if we are to bring about positive change.

Every tour's success depends on a skilled leader's ability to communicate persuasively. Dr. Johnson is already making us proud. ▲

Illinois Medicine

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Harold L. Jensen, M.D., *Chairman of the Board*

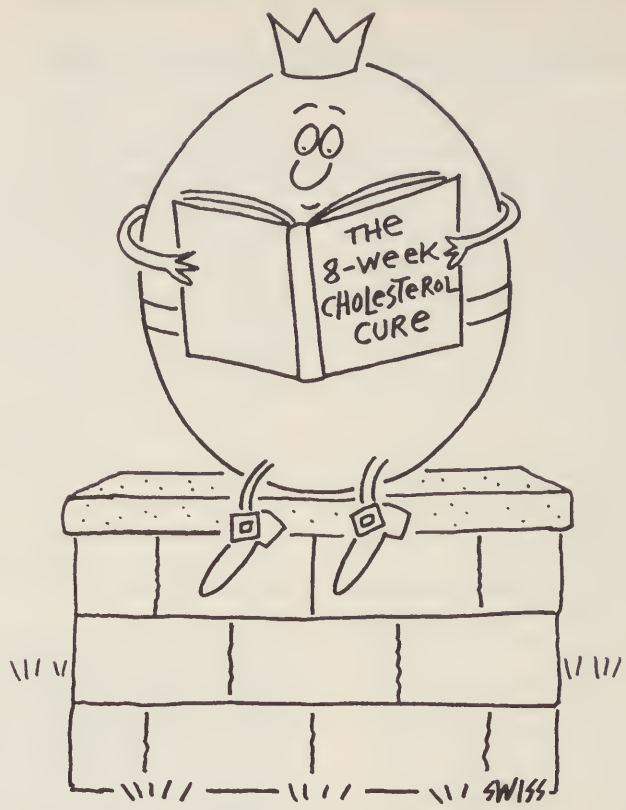
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President's Column

Taking a "good news, bad news" show on the road



Eugene P. Johnson, M.D.

My job as ISMS president is to bring to our members and the public the ISMS message. It is also my job to bring their messages back to ISMS leadership. Since becoming ISMS president in April, I have met with many members throughout the state in formal and informal gatherings. Called the "President's Tour" this trek back and forth across the state is my main duty as president, and I take it seriously. With the advent of fall, the pace of the President's Tour increases.

My message to members could be labeled the "good news, bad news" routine. The good news is our 1989 legislative accomplishments, including public aid increases, protection and extension of tort reforms and defeat of mandatory Medicare assignment, to name just a few. Some of the bad news includes the threat of mandatory assignment battles in future legislative sessions, as well as the ominous prospect of Medicare expenditure targets at the federal level that will force physicians into the role of "rationer of care".

There are opportunities ahead for ISMS also. The 1990 elections signal changes in Governor and other statewide offices, not to mention legislative races so important for the coming decade, due to the fact that those elected will be charged with redrawing state legislative and congressional district lines. There are legislative opportunities for ISMS to be a part of the indigent and rural health care solutions, as well as attempts to pass meaningful anti-smoking legislation.

One message to members will be to ask for your individual participation in our ISMS campaign to reach out to senior citizens as patients and in groups to reestablish physicians and patients as natural allies.

As I meet with the media and the public, my message will center around society's dilemma of wanting the very best medical care for all its citizens, without the will or knowing the way to pay for it. I will try to make the case that physicians did not cause this dilemma, but that we *are* willing to work with other segments of society, including government, business, other health care providers and patients, to try to find solutions.

Finally, I want advocates for a Canadian health care system in this country to understand the significant tradeoffs such a change will pose: rationing of and longer waits for care; less availability of technology, as well as little development of new technology and procedures for diagnosis and treatment. And there's no guarantee that a Canadian-type system will cost less.

The American health care system can best be described the way a statesman once described democracy: It's the worst system in the world, but no one has developed any better. ▲

E. P. Johnson M.D.

Eugene P. Johnson, M.D.
President

Illinois Medicine *recently invited readers to share comments on the controversial abortion issue. The first of these were published in the September 1 issue of* Illinois Medicine. *Additional letters will be published in future issues as space permits.*



Illustration: Michael Jones

There can be no doubt that the conceptus and all stages that follow are truly human life, and as such must be protected. All the genetic material is well known to be present within this one cell, and any division of stages between non-human and human after conception must therefore be purely arbitrary. The old theory that "ontogeny recapitulates phylogeny" has been thoroughly debunked, so that there is no such thing as a "fish stage" through which the embryo passes, even though there are reports that this kind of reasoning is still used.

In addition, what happened to the Hippocratic Oath, which originally proscribed abortion? Why should something that has remained intact through many centuries suddenly be changed to fit the whim of the current generation?

The state should restrict abortion to those that are necessary for saving the life of the mother. And while I do not believe that "two wrongs make a right," it would probably be politically necessary to also permit it in the cases of rape and incest.

David G. Springer, M.D.
Peoria

I view the state as not entitled to legal jurisdiction for or against abortion; and I view the adversaries as obligated to respect that our society protects a pluralism of perspectives on abortion.

The arguments for and against abortion in our society have generated passion, indignation, and a sense of morally righteous outrage from their separate positions of narrow advocacy.

The unappreciated but overriding issue is one of an unreconciled conflict between differing faith positions. The principles for resolution lie in the spirit of the First Amendment of our Constitution, which says that there shall be no laws pertaining to the establishment of religion.

The conflicting positions on abortion derive from long-established separate religious premises of personhood. These premises are sufficiently different that their arguments, and deductions derived from them fail to meet on common ground.

One premise is that human life and the soul begin at conception. Therefore, the fetus is already a human being, and its destruction is murder.

The other premise is that one does not become a person until he or she is born. This has been repeatedly recognized in the common practice of defining one's identity as beginning on the date of birth. The fetus is considered part of the mother's body until that time.

Historically, there has been an implied social contract in our nation that obligates differing faith positions to respect each other's views and practices of conscience. One is not privileged to impose his alternative morality on someone of contrary belief. However, the anti-abortion proponents are proposing to do just that, believing that in so doing they are being true to their faith position. They find the pro-abortion position to be odious, and they deny its right to exist.

The pro-abortion proponents, however, in no way insist on imposing abortion on the lives of those who would not have it. They do not consider their values to have jurisdiction in the lives of people of contrary belief. The latter, on the other hand, publicly demand jurisdiction in the consciences of those favoring abortion. A campaign of intolerant, libelous defamation has been under way, with an ultimate goal being the state's establishment of their faith position as law.

This will endanger the social contract under which we have been living. It is a contract that says that there is room for all; and it has, until now, protected a pluralism of beliefs without the intrusion of governmental favoritism. We do not need to move toward the Ayatollah's world where "the 'truth' of my faith grants no right for any blasphemous alternative to publicly exist." On the contrary, in our society, ideas of a faith's "truths" must stand by their own internal spiritual strengths, without the external power of the state law to uphold them.

Earl N. Solon, M.D.
Park Ridge

In light of the recent Supreme Court decision, I am writing to you in support of a woman's right to choose an abortion if she feels it is necessary.

As a physician, I have had the unfortunate task of assisting in abortions on women whose health was at risk because of their pregnancy. It is unconscionable that we would consider denying this medical procedure if it would save a woman's life.

As a pediatrician, I have had the unfortunate task of caring for children whose mothers cannot care for them, but who could not afford to have an abortion. Although abortion should be discouraged as a form of birth control, I feel that for social reasons we must continue to make it available to those in need.

I have found myself arguing with other men who cannot understand the burden that bearing and raising a child places on a woman. A woman should have the right to protect her body, and to decide when and whether she wants to be pregnant.

Therefore I urge you to make all efforts to protect every woman's right to make her own reproductive choices. I also urge you to fight attempts to restrict the availability of abortions either by imposing undue regulations on abortion clinics or by requiring physicians to test the viability of a fetus. Viability testing puts both the woman and the fetus at increased risk, and is a medical procedure that is potentially being forced on an unwilling patient.

Our elected officials have the duty to represent the wishes of their constituency, and the majority of us wish to keep abortion safe and legal.

Baruch S. Ticho, M.D., Ph.D.
Chicago

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

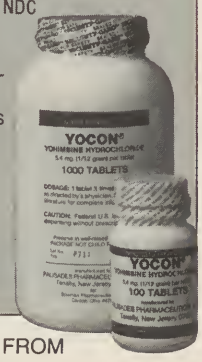
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Insurer cites "implied warranty" for MD service

Madison County plastic surgeon put on notice

By Eileen Norris

A PLASTIC surgeon performs a breast reduction on a woman for medically necessary reasons. A couple of months later complications arise and a second surgery corrects the problem.

But soon after that, the patient's insurer sends the physician a letter saying it refused to pay for the second operation because there was an "implied warranty" the job would be done right the first time.

"Does this mean that every time there is a surgical complication or an 'imperfect' result, the doctor is responsible for the cost of the followup care?" asks Michael Beatty, M.D., a plastic surgeon in Edwardsville, Illinois, and president of the Madison County Medical Society. Dr. Beatty recently found himself facing this very real question.

"I don't know if this phenomenon is widespread or if I'm the only one



with the problem, but my fear is that payers are implying doctors are responsible for untoward results," says Dr. Beatty.

The insurer, Benefit Trust Life Insurance Company of Clayton, Missouri said in a letter to Dr. Beatty there is an implied warranty that he do the surgery, "do it correctly, and if not, correct it without further charge." Repeated attempts to reach Benefit Trust for further comment and clarification were unsuccessful.

According to Dr. Beatty, the insurer said its findings were based on the "AMA's criteria for implied warranty," but the American Medical Association in Chicago says it has no such guidelines.

The AMA has consistently recommended to doctors that they carefully consider when making specific claims or guarantees as to the successful outcome of a surgical procedure, says spokesman Dan Maier.

"There's an implied warranty that every doctor has the skills in his or her specialty and that he'll do his best to get a satisfactory outcome," he adds. "But we've never heard of an implied warranty in the surgical context."

Legal experts miffed

Several medical legal experts and even one large Chicago area insurer are miffed over the insurer's logic in disputing the claim.

The term is common in cases where goods and products are used in surgery, says Gene Basanta, J.D., a Southern Illinois University professor in the school of law and co-author of *Law of Medical Practice In Illinois.*

"I've seen that defense used when a pacemaker or a boneplate, for example, are found to be defective and the patient successfully sues on the grounds that there is an 'implied warranty' the goods will perform," he says.

But most doctors wouldn't give an expressed warranty or guarantee the results of a surgical procedure. Generally, adds Basanta, it's not proper for a physician to make any promises.

"The only time there would be an implied warranty would be if there was a contractual agreement or an oral promise made, but I've never heard of a case where a doctor was expected to eat the cost of follow-up surgery resulting from complications," he adds.

Indeed, Dr. Beatty said he didn't have a contractual agreement with either the patient or the insurer when he performed the medically necessary breast reduction on the woman, who later developed complications from the mammoplasty and had to return to the operating room.

"I had no problem with the reduced payment for the second surgery and I finally agreed to that with the insurer," said Dr. Beatty. "But what I don't like is the implication that the doctor is responsible for the cost if there is not a perfect result."

"It sounds to me like it was a medically indicated procedure," says Ted LeBlang, J.D., legal counsel to SIU's medical school and co-author of the book, *Law of Medical Practice in Illinois.*

"So, it makes no sense to me whatsoever that the insurer would expect the physician to pay for the subsequent surgery himself. If the insurer is indicating that the physician breached the standard of care, that's one thing, and if that's the case, it should come out and say that.

"But if this were a negligence case, the patient would have the right to initiate litigation. The doctor would be liable only if the patient prevailed in the litigation," he adds.

Implied warranty actions are usually seen in a product context, not a service context, says John Blum, director of the Health Care Law Institute at Loyola University in Chicago.

"It's an interesting case, because it raises a whole new set of angles payers could use in denying insurance claims," he adds.

That may be true, but Blue Cross/Blue Shield of Illinois, for one, doesn't condone the tack Benefit Trust took in denying full payment of the second claim.

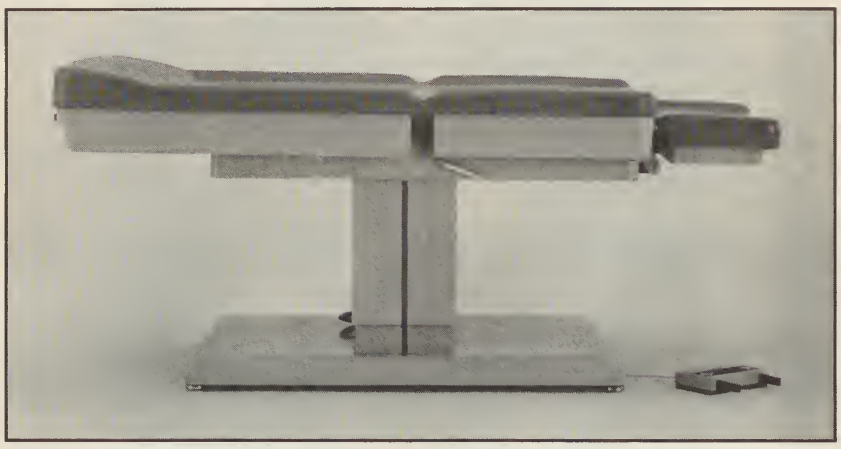
"That's going over the bounds," says Joe Arango, manager of provider network development at BC/BS in Chicago. "We don't sit in judgment as to whether a doctor made a mistake or not. There are complications in medicine and doctors are allowed to be compensated for their time." ▲

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Good news for retiring ISMIE policyholders

PHYSICIANS WHO retire and who are eligible for reporting endorsement (tail) coverage from the Illinois State Medical Inter-Insurance Exchange can now obtain the tail coverage *and* provide medical care in a free medical clinic and/or work in an administrative capacity where there is no rendering of professional services to patients. The Illinois State Medical Insurance Services approved this change in the granting of a retirement "tail" at its regular monthly board meeting Wednesday, September 6, 1989. The change goes into effect immediately.

The care provided in a free medical clinic must be in accordance with the current Medical Practice Act, Section 4400-31. Administrative positions include teaching at a medical school, performing utilization review, reviewing medical records for an insurance company or serving as medical director of a nursing home or a health maintenance organization. More details on this ISMIE policy change will be included in the next issue of *Illinois Medicine.* ▲

Can this practice be saved?

Some problems are more than cosmetic

by Ruth Kalish, Ph.D.

ON THE SURFACE, Drs. Thomas Simon and Ellen Hayworth seemed to have everything going for them. Partners for nearly 15 years in cosmetic and reconstructive surgery practice, they were a compatible, hard-working team with excellent reputations. Their patients, predominantly middle-aged women, seemed pleased with their surgery. This attractive office was in a high-visibility location in a prestigious suburb.

But if the practice offered such a flattering picture, why had their patient base been steadily declining for the past few years?

The first clues to the mystery came from the offices themselves. On my first visit, the waiting room was full. The receptionist, whose desk was cluttered, was irritable. Her desk, set in the middle of the open waiting area, allowed visitors to hear her discussing sensitive patient information on the telephone. Behind her, the open doors to the doctors' offices revealed desks piled high with papers. A large part of the problem was immediately clear: Surgery is a very exacting specialty. If a plastic surgeon's offices do not reflect that precision and order, it can create a serious image problem.

Research into the practice's staff, patients, and finances pinpointed additional problems:

- The doctors had no organized method for tracking referrals, cultivating referring physicians or entering new markets. They depended on word-of-mouth advertising.
- One of the doctors was disorganized and chronically late, which greatly annoyed staff members. The resulting high rate of staff turnover was expensive and contributed to general confusion in the office.
- Although happy with the results of their surgery, patients complained about not knowing what to expect during and after surgery. They also said they often were kept waiting, and they sensed the tension and disorder in the office.

What happened to this practice is not uncommon. A surgeon's talent does not always translate into being an effective organizer, people manager (of staff *or* patients), or marketer. Following our report and recommendations, Drs. Simon and Hayworth took some major steps to change the direction of their practice, including:

- Reorganizing the front office, giving the receptionist and her callers more privacy and creating a more professional appearance;
- Creating a patient education program that included private patient-nurse consultation and print and audiovisual materials to help patients understand the surgery and recovery process;
- Asking staff to set up a new scheduling system, which reduced both patient waiting time and staff frustration;
- Hiring outside communications experts to develop a sophisticated "image" brochure and other print pieces for targeted audiences; and
- Building referrals by more networking with other physicians through mailings and conferences. To reach the community directly, the doctors began participating in health fairs, and seeking out speaking engagements with local groups.



Ruth Kalish, Ph.D.

The effects of these changes were dramatic. Within 18 months, patient and staff satisfaction had improved dramatically. Referrals were up as well—in fact, the patient load grew so significantly that the partners are considering adding another surgeon.

If the partners had taken any *one* of the recommended steps, it would have had little effect. It was a combination of problems that was eroding the practice, and it was a combination of solutions that turned it around. ▲

Dr. Kalish is a Chicago-based principal and partner of the Practice Enhancement Institute.

"Managing Your Practice" is a new column written by practice management consultants who serve Illinois clients. The practices described are real, although names have been changed to preserve confidentiality.

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Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS
Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of nonsusceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.
Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
• Gastrointestinal (mostly diarrhea): 2.5%.
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%; usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
• Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia.
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(continued from page 1)

responded, 'You're right, doc. We're going to emphasize quality.'" Dr. Murphy laments that "Medicare defines quality, they tell you how to do the job."

Who measures quality, and how?

Despite the divergent and often emotional opinions on why and how well Medicare's PRO is conducting them, quality reviews are being done at an average rate of 6000 medical chart investigations monthly. A nurse coordinator uses generic screens—some supplied by Medicare and others developed by CCFMC—to flag cases warranting further, physician review. After the nurse coordinator's initial selection, a physician reviewer looks over each case.

"If that physician feels there is a potential quality issue, the case is then referred into Crescent Counties' quality department, where a reviewer matched to the specialty of the physician once again reviews the medical records," says Kathy LaSpina, CCFMC's director of quality assurance review services. (See the accompanying chart for a detailed look at the various stages of PRO quality review).

If quality concerns persist, this physician specialist launches the case into the quality review process, with physician reviewer comments providing the basis for letters asking Illinois physicians to respond to potential quality issues raised.

Inconsistency vs. cookbook medicine

What yardstick do these specialty-physician reviewers use to measure quality, or its absence? "None of the physician reviewers use screens or criteria," acknowledges LaSpina. "They use medical judgment." The PRO sees that as a plus in assuring that "it uses professional consensus to establish a broad range of acceptable treatment plans. The review system is intended to identify those physicians who practice medicine in ways not accepted by most of their peers," she adds.

But Dr. Vautrain calls this lack of standards an "idiosyncratic standard of care. They're using a standard of care that is private, individual and unavailable to anyone else," he says.

The people who complain about consistency are, quite frankly, the ones who rail about 'cookbook medicine.'

University of Chicago internist John Schneider, M.D., concurs with Dr. Vautrain. "Physician reviewers are making up the rules as they go along. The PRO doesn't tell us what those rules are. They do put out quality review bulletins, but only circulate them among their reviewers." CCFMC officials indicated that the quarterly bulletins are not circulated to physicians but are distributed beyond reviewers at "PRO/IHA regional meetings throughout the state."

According to CCFMC statistics, approximately 50 percent of cases are reversed at the first review level, after scrutiny by an MD specialist. Another 50 percent of those moving up to the next level are closed after attending physicians respond to PRO quality letters. In short, as many cases are weeded out of the system after additional, higher level reviews as are advanced. "Much of the time, reversals are due to new information, not shown on the medical record," explains LaSpina.

Even so, some PRO critics including Dr. Vautrain conclude, "You cannot justify a system that generates a whole lot of citations, even though they're mostly overturned. That's like charging you with a crime and forcing you to defend yourself," he says.

But the PRO's Dr. White urges caution on the part of physicians who would trade in local peer review for defined practice standards. "It's very hard to define a practice standard that's meaningful and still gives physicians the flexibility to tailor therapy to individual patients."

He sees inconsistency as an unavoidable by-product to localized peer review and "is not disturbed by that. As more physicians review the chart, we identify more and more of these grey areas where there's just simple disagreement, and no quality issue," he explains. "I've heard [Medicare's] inspector general talk about regionalizing or nationalizing the review process. Local physicians wouldn't have any role. And that scares me," he warns.

Dr. White argues that "the people who complain about consistency are, quite frankly, the ones who rail about 'cookbook medicine.' If you're going to have a 'cookbook,' you're going to have consistency, but then you don't have any flexibility. If you have flexibility, you're going to have grey areas."

The American Medical Association and the Health Care Financing Administration (HCFA), Medicare's administrative arm, are both investigating practice parameters, or standards, to provide general benchmarks in the review process. Besides their potential impact on Medicare quality review, such measures raise medical liability questions regarding local standards of care.

Ranking quality concerns

The PRO ranks potential quality issues according to severity. "HCFA has mandated the use of three different levels," says LaSpina, "and also the category 'gross and flagrant' which can be attached to any level."

Level one involves "medical mismanagement without the potential for significant adverse effects on the patient." In past years, the PRO sent physicians letters regarding all level one quality concerns, no matter how minor. This raised physicians' ire that they were being harassed by Medicare for nonsubstantive issues.

Under a new, nationwide PRO policy all level one quality issues are diverted to a "pending" track, where they are held to see if a pattern of such lapses on the part of an individual physician shows up over time. The cases are reactivated upon "a pattern of three in three months or five in six months, and then we would send one communication on that group of cases," says LaSpina.

But some doctors disagree with the PRO's new philosophy of waiting to notify doctors of potential quality citations. "I think it's purely a cost cutting device to save Medicare money and all the rigamarole of notifying you," says Dr. Murphy. "If it's important enough to keep an official tab on me, and if these minors add up to a major somehow, it's important enough to let me know from day one."

Illinois physicians can't have it both ways, responds CCFMC's Dr. White. "Medicare agreed to this because physicians were squawking about the number of minor issues. Either we pend these minor issues and notify physicians if there's a pattern, or we notify physicians about all of them. We're certainly not going to ignore them," he says.

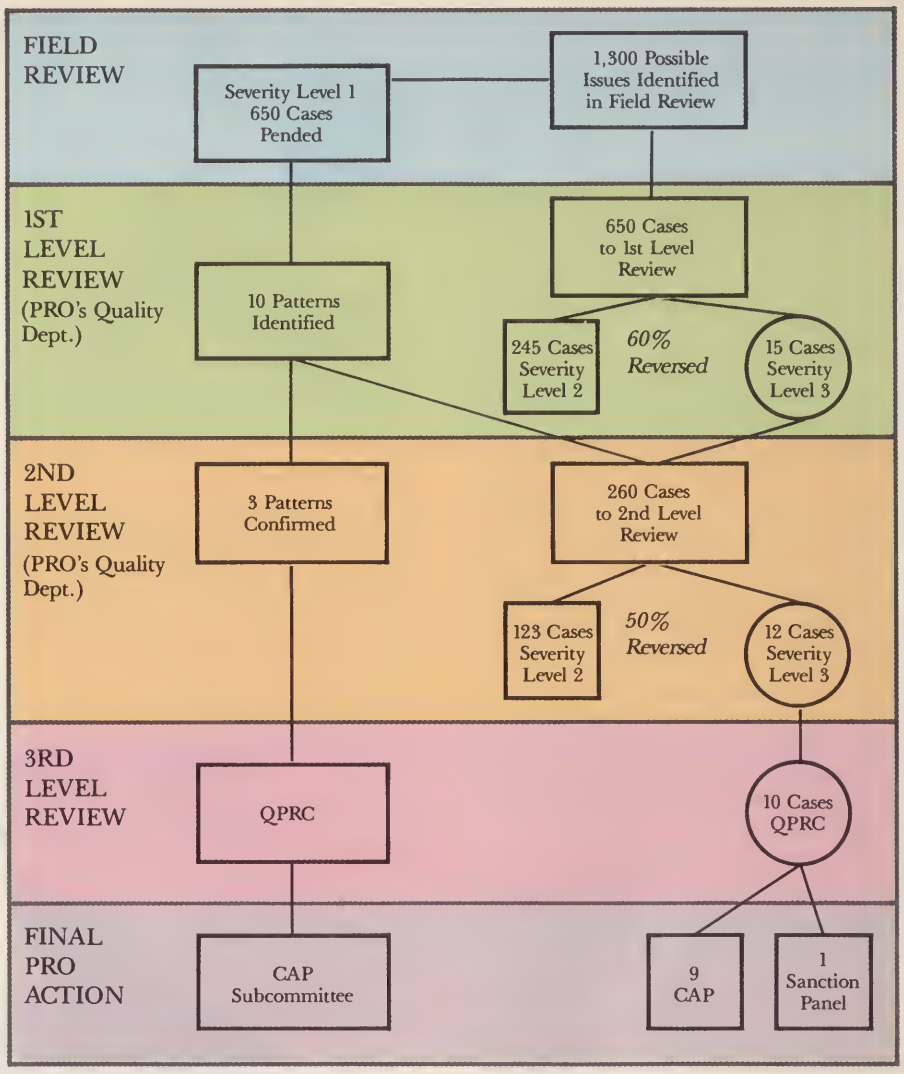
A level two severity rank indicates "medical mismanagement with the potential for significant adverse effects on the patient." The most serious potential quality breach is termed level three, "medical mismanagement with significant adverse effects on the patient."

Quality issues most frequently cited

Illinois PRO data show that by far the most frequently arising quality issue, "failure to address abnormal labs," accounts for 63 percent of cases. A distant second at nine percent frequency is "drug serum levels not addressed." "Inadequate workups," "no cardiac monitoring," "inappropriate treatment," "subtherapeutic drug dosage," "antibiotics started—no cultures ordered" and "failure to address secondary conditions" make up the remainder.

Dr. Schneider disagrees fundamentally with the Illinois PRO's way of scrutinizing quality issues. "Do you try to find somebody screwing up, or do you attempt to look at what a group or an individual physician does overall?" he asks. He believes CCFMC's process, concentrated on dealing with individual instances and single medical cases, is misdirected. "You've got to look at the total practice of the physician," he argues. "You've got to be able to say, 'This is what happens with Dr. Schneider's

PRO Quality Reviews: A Look at the Process



The PRO reviews an average 6,000 cases monthly, although total volume can vary widely from month to month. During FIELD REVIEW, nurse coordinators review all cases. Those not approved go to field physician reviewer for further scrutiny. Approximately 1,300 are found by the physician to have potential quality problems, and are ranked according to severity. About half of those are labeled severity level 1 cases (minor quality issues), and are slotted to a separate "pending" track to see if a pattern develops over a three to six month period. The others are forwarded to first level quality review.

Of the 650 cases reaching FIRST LEVEL QUALITY REVIEW, approximately 60 percent are reversed and closed. Severity level 1 patterns are identified and reviewed at this stage. An MD specialist matched to the case conducts the review. Cases not reversed are again assigned a severity rank (depending on seriousness of potential issue). Upon completion of FIRST LEVEL QUALITY REVIEW, the PRO sends a letter to the MD, requesting a response to the issues in question.

At SECOND REVIEW LEVEL, the PRO hears from attending physicians responding to quality letters. After such dialogue, another 50 percent of cases are reversed and closed. In the absence of MD response, severity level 2 cases are automatically upheld without further review. Cases with a severity 3 ranking are re-reviewed by physician specialists and subspecialists, with or without the attending physician's response. Unless reversed, these cases can move up to a third review level.

THIRD REVIEW LEVEL concentrates on the most serious quality issues, through scrutiny by the PRO's Quality Peer Review Committee (QPRC). QPRC can also take any action needed on confirmed patterns of minor (severity rank 1) quality violations.

This is the Illinois PRO's FINAL ACTION stage. The QPRC refers the approximately 10 cases shown — out of 6,000 initially reviewed — for a corrective action plan (CAP) or sanction panel. Sanction recommendations are voted on by the full PRO board before being forwarded to the federal government's Office of the Inspector General, which considers the PRO recommendation but may change it.

diabetics. They have an admission rate of one out of 100 per year, whereas the nationwide average is X.' The trouble is the PRO focuses on finding [single] errors," he says.

PRO quality review chief Dr. White does not disagree with this philosophy. "That's absolutely right and that's what we do. When we identify a potentially serious, rank three quality issue, we will pull 20 to 25 charts on that physician, on that type of patient," he stresses. For more minor quality questions, however, he acknowledges that the PRO does not go to such lengths.

Confidentiality, communication

PRO quality deliberations are confidential, as are the names of MD reviewers. And when a physician's attorney calls the PRO for information, "we refer the call to our legal counsel," says LaSpina. "We will be happy to speak with physicians, but we don't speak with attorneys."

We will be happy to speak with physicians, but we don't speak with attorneys.

While reviewer anonymity irks some physicians who want the opportunity to confront their accusers, federal regulations prohibit the PRO from releasing the names of physician reviewers without their permission. "I should have the opportunity to defend myself, to have due process, to be able to say, 'Who said I did it wrong?'" says Dr. Murphy. As it stands now, "I can't call their witnesses. I don't even know who reviewed my case," he claims.

According to Dr. White, the PRO's protection of their several hundred physician reviewers is because "they tell me they're seen as outcasts in their hospitals, they catch heat from the other physicians about what they do." In short, too much identity and visibility could make MDs reluctant to serve.

He adds that the PRO "offers a number of ways in which physicians can talk with actual reviewers. They can write us a letter, participate in a telephone conference with two physician reviewers, or come into one of our sites and meet with them in person. In fact, the more serious the potential quality issue, the more we would like to talk with the physician in person."

As for confidentiality of quality findings, final CCFMC determinations are not now publicly released. That may change in the near future, as HCFA considers issuing payment denials for confirmed quality breaches. "The big question is at what point in the process the beneficiary would be notified . . . before or after the opportunity for reconsideration," LaSpina points out.

The PRO does notify hospitals quarterly about all the confirmed quality citations issued to physicians on staff. The listing does not identify MDs, but does name individual patient cases.

Building understanding, dispelling myths

Rumors and myths about PRO practices run through Illinois' medical community and are difficult to halt, notes LaSpina. "I've heard we conduct secret sanctions, that we've sanctioned 2000 physicians, that our reviews are not done by MDs, that we don't use specialists, that our physician reviewers use criteria," she relates. "And if we have quotas [from HCFA] for sanctions and denials, I've never met them. That is the most persistent myth," she adds.

From the individual physician's perspective, however, the PRO could vastly improve its link with the profession through effective communication. "It's the biggest falling out between the individual practitioner and the PRO," says Dr. Murphy. "They are getting better in communicating with the medical society," he adds, "but they have really not improved any communication with the individual. I've received zero communications from the PRO, as an individual doctor in my office."

Don't throw that letter about a potential quality issue away. Don't blow us off.

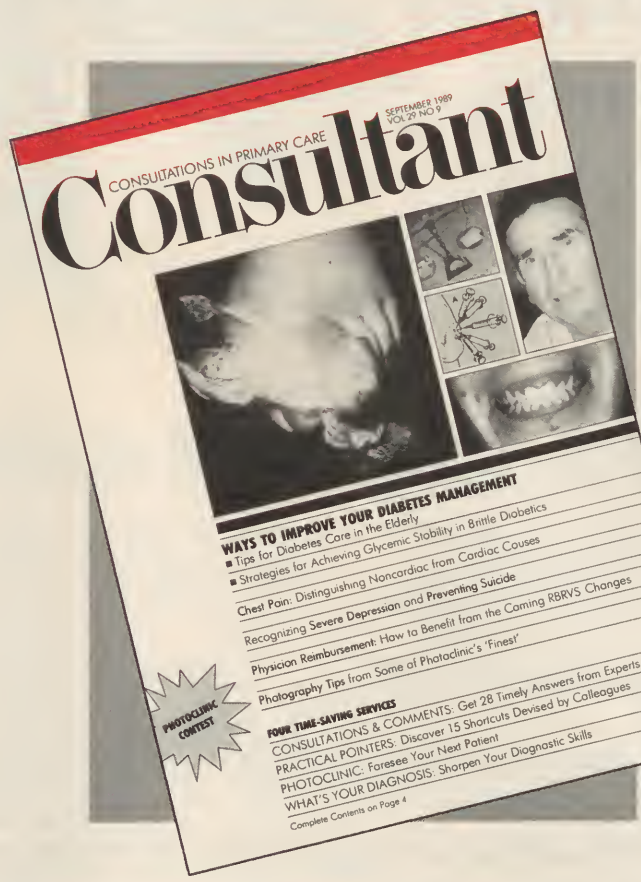
"I think the most important thing a physician can do is respond to PRO correspondence," advises Dr. White. "Don't throw that letter about a potential quality issue away. Don't blow us off," he stresses.

Dr. White often reminds his peers that very few physicians go on through the formal process. "There have been four physicians sanctioned so far, out of 25,000 in the state of Illinois. They were physicians who demonstrated multiple deficiencies. It wasn't a situation where they did one or two, but 20 or 30 things wrong. They're the sort of mistakes that make you shake your head and say, 'Gee, how could somebody do that?'"

The Illinois State Medical Society's division of health care finance is available to assist member physicians who have questions or concerns about PRO. ▲

Next—Medicare utilization review: MDs in the middle

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CME requirements "fairly loose"

by Karen Sandrick

THE ILLINOIS LEGISLATURE over the years has vacillated over whether physicians should be required to participate in continuing medical education (CME) in order to retain the license to practice medicine. A number of years ago, Illinois law mandated that physicians accumulate 100 hours of CME during the licensure period; more recently, the state's professional practice statute has required no CME.

Dean R. Bordeaux, M.D., chairman of the Illinois State Medical Society's (ISMS) committee on CME accreditation, recalls, "In the beginning there was a press for a CME requirement for relicensure. That was written into the law, and there were definite CME requirements—so many hours of Category 1 programs and so many hours of Category 2 programs or comparable kinds of accredited programs.

"But [CME requirements] were taken out of the old Medical Practice Act, so we lived for several years without a requirement for CME for relicensure," explains Dr. Bordeaux.

Medical Practice Act provisions

The Medical Practice Act of 1987 again requires CME for relicensure; it establishes a structure for reviewing physicians' CME records and sets penalties, ranging from a reprimand to a license suspension, for failing to meet the CME requisite. Yet the Act does not require a set number of CME hours.

The new Medical Practice Act acknowledges that "continuing education is part of the responsibility of individuals licensed to practice medicine . . . that physicians should take it upon themselves to do continuing education," says Jean Courtney, rules coordinator of the Illinois Department of Professional Regulation (DPR).

A specific number of CME hours was not imposed, however, so physicians would not have to "go out to courses just to gather enough credits," she adds.

The current Medical Practice Act reflects what Illinois physicians are already doing. A recent survey of 2,296 ISMS members showed that in one year physicians spend, on average, 136 hours in formal CME programs and individual educational activities primarily to foster their own professional development. Licensing and other requirements for CME fell far behind personal growth as physicians' prime motivation for engaging in CME.

"The Illinois regulations seem to be fairly loose and allow each physician to make up his own mind [about the number and type of CME programs to attend]," says Peter O. Fried, M.D., chairman of the ISMS committee on CME activities.

Showing proof for relicensure

Physicians will be asked, at the end of the three-year relicensure period, whether they have participated in CME. Then, at the time of relicensure, DPR will audit a certain percentage of physicians to obtain verification of their CME participation.

"Somewhere around 10 percent of physicians in the state will be randomly selected by computer and asked to submit proof of CME," explains Courtney.

This proof may consist of:

☐ certificates of attendance at formal educational programs conducted or endorsed by hospitals or specialty societies, or programs accredited by the Accreditation Council for CME, ISMS, the Committee on Continuing Medical Education of the American Osteopathic Association, or the Illinois Association of Osteopathic Physicians and Surgeons;

☐ transcripts from postgraduate courses taken in medical schools;

☐ records of attendance/completion of formal CME programs conducted to prepare individuals for licensure;

☐ notices of recertification (and the educational requirements necessary to obtain recertification) from specialty boards;

☐ evidence of membership in medical associations that require CME; and

☐ letters from deans of medical schools verifying faculty status and/or teaching activities.

"Reading journals or viewing audiovisual materials is another way of meeting the CME requirement," says Courtney. Proof of participation in these types of educational activities (for example, journal subscription slips, proofs of purchase of audiovisual materials, and copies of completed self-examination) may be acceptable.

Meeting requirements for a specific number of CME hours in years past was burdensome for some physicians, particularly those who were semi-retired or lived in rural areas and therefore could not easily attend formal CME programs, Courtney points out.

It also may have been ineffectual. "You can legislate that physicians must attend CME and put in certain hour requirements, but you can't legislate people's behavior," says Dr. Fried.

"It is quite easy to attend programs, to gain CME hours, and not necessarily learn a thing," Dr. Fried adds.

The Medical Practice Act of 1987 frees physicians to seek out CME activities that will be most valuable and illuminating for them. And, as long as physicians "do at least some type of continuing education and keep records of continuing education, there is no reason why any physician would not be able to meet the CME requirements," Courtney concludes. ▲

ISMS receives ACCME accreditation

IN MARCH 1987, for the first time in its history, the Illinois State Medical Society (ISMS) was accredited as a sponsor of continuing medical education programs by the national Accreditation Council for Continuing Medical Education (ACCME). In March 1989, ACCME reaccredited ISMS to sponsor CME programs for the next four years.

As an accredited sponsor, ISMS must develop educational programs that meet its' members needs. Because of survey results indicating that ISMS members prefer short, one- or two-day programs in their locale, the medical society is working at the grassroots level to provide education through county medical societies.

"County medical societies are able to get a pretty good handle on what their physicians need in terms of clinical programming, and they have the ability to address most programming needs within their own county," says Peter O. Fried, M.D., chairman of the ISMS committee on CME activities.

The ISMS committee on CME activities therefore is examining the possibility of creating a statewide CME information clearinghouse that catalogues who has or is capable of speaking to local medical groups on designated topics.

The medical society also is helping community hospitals devise educational programs to address their medical staffs' particular concerns. The society offers CME program development consultation for individual hospitals and will hold a CME planning workshop on October 6, 1989 at the Schaumburg Hyatt Hotel, to train hospital CME staff members and physician members of hospital CME committees in planning and conducting programs. ▲

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PUBLIC HEALTH REPORT

by Judy Alsofrom

The case of the indigenous arbovirus

The Illinois Department of Public Health (IDPH) reported a recent outbreak of indigenous arboviruses.

The arboviruses, spread by the state's mosquito population, cause aseptic menengitis, St. Louis encephalitis or California encephalitis.

In fact, the nation's first case of St. Louis encephalitis was contracted July 4 by a McLean County woman. IDPH says the exact site of exposure is not known because she had traveled in several other counties before becoming ill. The length of exposure was greatest in her home county, and so officials feel certain the case exposure was there.

Treatment for the arboviruses in general is not effective, according to IDPH officials, but treatment can be prescribed for some of the symptoms. The woman has recovered sufficiently from her bout with St. Louis encephalitis to be released from the hospital, but as yet has not returned to work. One probable case of California encephalitis has been reported in Taswell County.

There are 117 other cases with signs and symptoms of arbovirus awaiting confirmation by serological testing.

Half the cases have been from the Chicago metropolitan area and the rest sprinkled around the state. There appeared to be no discrimination among the different age categories, with equal numbers of cases in 10 year increments from ages 1 to 50 and to some numbers in patients older than 50.

A case of Q-fever

IDPH also reported a case of Q-fever, a disease that acts much like a lower respiratory infection.

Q-fever is hard to diagnose, according to IDPH, simply because it doesn't occur very often. There have been less than five cases reported in the U.S. this year.

The Q-fever case in the state occurred in a dairy worker who sold milk cows. Milk from these cows that was pasteurized was safe, but public health officials tried to track down all the customers of the raw milk sold from these cows. Of those customers they found, none contracted the disease.

IDPH suggests there is a moral to the Q-fever story: if physicians have a patient with symptoms of lower respiratory infection that seem slightly out of the ordinary, they should inquire about the patient's consumption of raw milk. ▲

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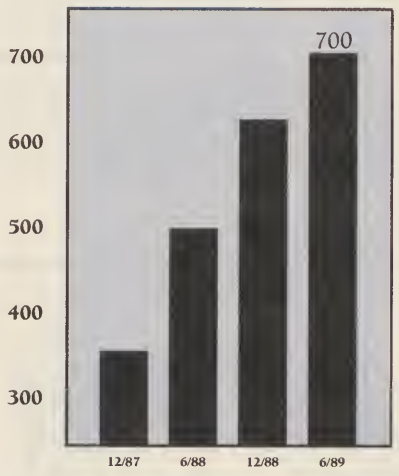
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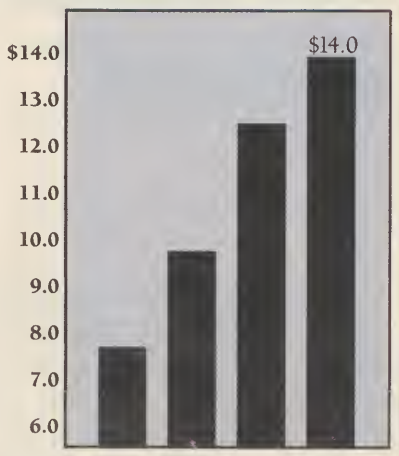
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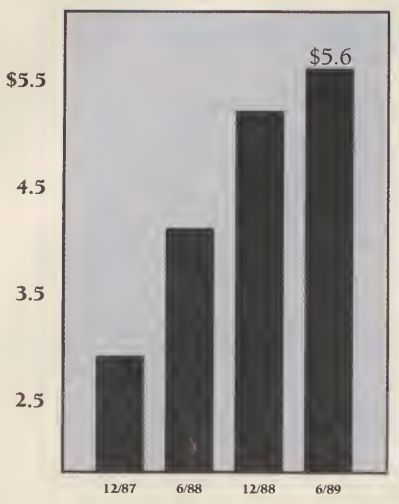
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Ragsdale case
(continued from page 1)



Photo: Jon McGinty

the 1973 case which made abortions legal in the U.S., according to pro-choice advocates who favor a settlement.

"It's quite likely [that *Roe* v. *Wade* could be overturned]. The numbers on the Supreme Court are not like they were in 1973," said Illinois Pro-Choice Alliance head Sue Purrington. Purrington cited the Court's decision in *Webster* v. *Reproductive Health Services* last July as indication that a 5-4 vote against Ragsdale is possible.

IDPH spokesman Thomas Schafer said that Dr. Turnock would consider a settlement proposal provided it ensured the health and safety of women obtaining abortions, and withstood the legal impediments already in force. Schafer emphasized, however, that Dr. Turnock has not yet received any proposal.

The case puts Democratic gubernatorial candidate Attorney General Neil Hartigan in a political quandary. On the one hand, it is his office that must argue the Ragsdale case before the Supreme Court. On the other hand, Hartigan recently announced that, although he personally opposes abortion, he would as governor veto any legislation that eroded a woman's right to choose. Hartigan would not comment directly on the settlement reports.

In 1985, Rockford physician Richard Ragsdale, M.D., lost his lease on an abortion clinic he operated. Dr. Ragsdale claimed that complying with certificate of need (CON) regulations under the state Ambulatory Surgical Treatment Center (ASTC) Act made relocation prohibitively expensive, so he sued the IDPH and Dr. Turnock.

In November 1985, the district court enjoined IDPH from enforcing the regulations against physicians who perform first or early trimester abortions in private facilities. The U.S. Court of Appeals on March 10, 1988 sustained the lower court saying that the CON requirements "may not be applied to ambulatory surgical treatment centers that plan to offer abortion services." The state appealed to the U.S. Supreme Court which announced earlier this summer that *Turnock* v. *Ragsdale* would be one of three abortion cases it would hear in the fall term. ▲

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Perinatal/Trauma levels

(continued from page 1)

Level 2 facility in the area. Cynthia Fraed, M.D., an OB/GYN in Marion fears the new code will close down Carbondale's perinatal program, forcing patients to drive for hours. "Under the proposal, Carbondale's perinatal program would fall apart. Its two neonatologists would be so restricted in their roles that the hospital couldn't justify keeping them. Mothers would have to drive three hours to the next closest Level 3 facility in St. Louis or Springfield. Some people in the southern part of the state would have to drive five to seven hours to a Level 3 perinatal center," she said.

"Carbondale Memorial Hospital is doing an excellent job of taking care of babies [as young as] 26 weeks and they've also been treating a fair amount of respiratory distress syndrome babies," said Dr. Fraed.

Level 2 standards



Florence Spyrow, United Medical Center, Moline

The proposal states that the Level 2 facilities' letters of agreement with their perinatal centers, "shall specifically identify whether treatment, consultation or transfer will be done for the following: gestation less than 34 weeks, 1800 grams or if the infant requires ventilation after initial stabilization for more than six hours."

Meanwhile, the Illinois Hospital Association (IHA) spoke out against three standards of care that cannot be granted to Level 2 facilities through the letter of agreement without IDPH's approval—for premature labor or premature birth less than or equal to 32 weeks gestation, birthweight less than or equal to 1250 grams and mechanical ventilation beyond the initial stabilization period of six hours. "We strongly urge that exceptions for these three conditions be left up to the hospitals. This is particularly apparent given the wide range of capabilities of Level 2 hospitals in Illinois," said Ann Guild of IHA.

Dr. Fraed said the effects of the proposal could be even worse in other rural areas of Illinois like Anna, about 45 miles south of Carbondale, where there is a large contingency of public aid patients, mostly high risk.

In favor of proposal

The Loyola University Perinatal Center (LUPC) in Maywood and Perinatal Association of Illinois (PAI), Springfield, favored IDPH's guidelines. "The proposed regionalized perinatal health care code emphasizes early identification of women at risk for poor pregnancy outcomes such as fetal death, stillbirths, low birth weight infants, preterm births and infants with identifiable medical problems," said Loretta Lattyak of LUPC. Loyola is a Level 1 facility. "Regionalized perinatal care is the cornerstone of public health's strategy to reduce infant mortality," said Phyllis Jones of PAI.

More problems

Harold Jensen, M.D., vice-president of medical affairs at Ingalls Memorial Hospital in Harvey, called for regulations that "support the delivery of prenatal care and the care for both low and high risk patients at the community level."



Photo courtesy University of Chicago Hospitals

Proposed perinatal networks aim to improve infant, maternal health.

Dr. Jensen noted that 30 percent of women who deliver at Ingalls are Medicaid patients. He said, "The regulations presume that high risk clients will come under the purview of the physicians and staff of the Level 3 centers through consultation or transfer. However, the majority of high risk clientele at Ingalls are not known to the medical staff prior to the time of delivery. Physicians who attempt to send high risk patients to Cook County Hospital or to Level 3 centers meet with great patient resistance. They sign out "against medical advice" if an ambulance is called to transfer them. They leave and return in late labor so they cannot be transferred."

Dr. Jensen also expressed concern regarding the issue of liability and cost effectiveness of the proposed rules. "While never hesitating to transfer a case beyond our expertise, after investing much money, manpower and support services, Ingalls can aptly handle high risk patients. However, we will no longer be able to use these resources if forced to transfer that baby to a higher cost, Level 3 perinatal center," he said.

Public comments were submitted through September 11. IDPH is reviewing the comments and will submit an evaluation to the joint committee on administrative rules. The committee will then have 45 days to give its recommendations to IDPH. If there are no further unresolved issues, the department can proceed with adoption of the rules. ▲



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Illinois Medicine

September 29, 1989

ILLINOIS STATE MEDICAL SOCIETY

Governor vetoes "off-label" drug use bill . . . 8

Concerns mount over trauma network

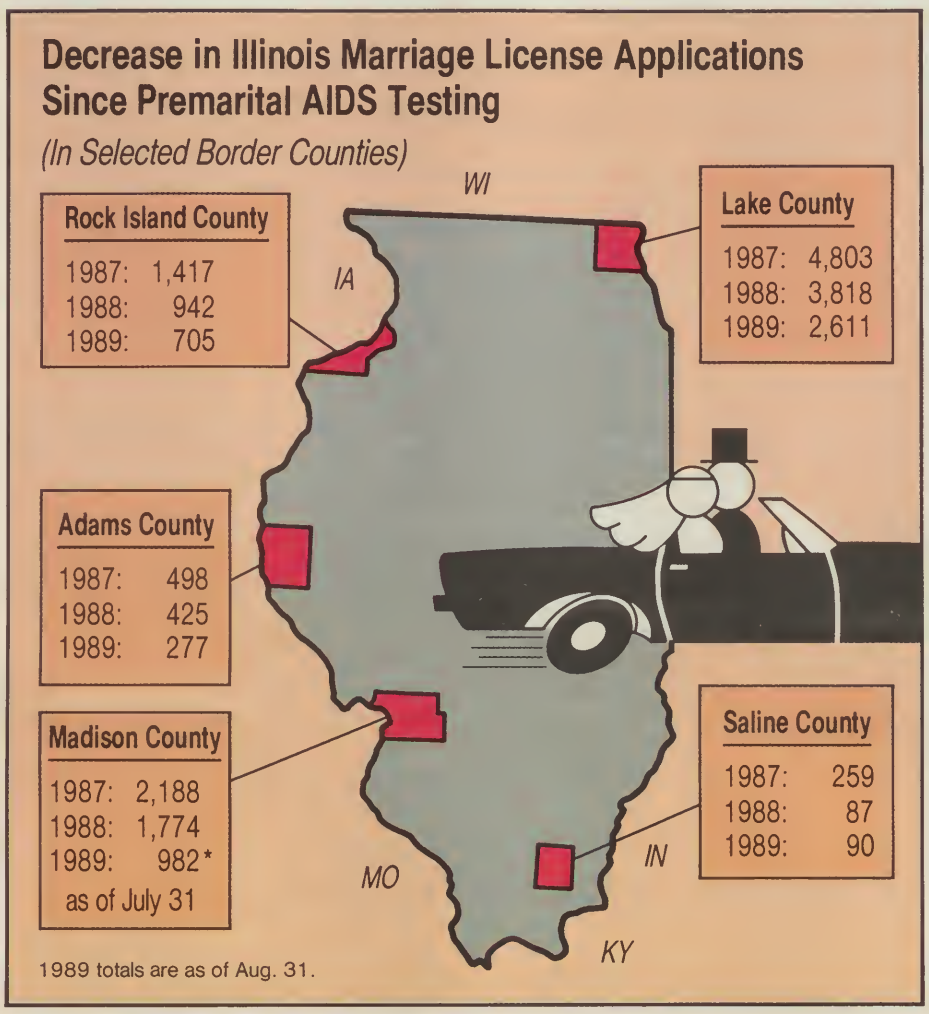
IMPROVING EMERGENCY care was what the Illinois Department of Public Health (IDPH) and the Chicago Health Department set out to do when they established a statewide and city trauma network just over a year ago. But, while some trauma experts maintain both systems "began to operate in a fairly effective manner," others claim involvement in the networks has since "turned sour," with some participants forecasting an "even drearier outlook" for several of the state's 76 hospitals granted level 1 and level 2 status.

Trauma system involvement, once alluding only to prestige and wider capabilities, has been massively characterized by regional disorganization and heavy financial losses. Critics agree there are no foreseeable solutions.

"Problems like these can occur within the network anywhere there is a large urban metropolitan area that provides extremely specialized trauma services. Costs can become very high in level 1 hospitals when treating largely Medicaid and uninsured patients and where regulations mandate in-house staff in extraordinary amounts," said Ron Damasauskas, vice president of pro-

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Thompson repeals AIDS law

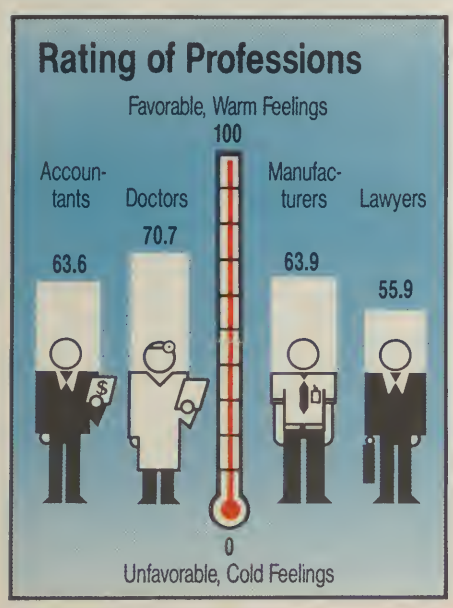


AFTER A 22 percent decline in individuals seeking Illinois marriage licenses, strong lobbying by health and medical organizations, and nearly two years of "mis-spending" large sums of money, Illinois' strategy on combating AIDS has taken a turn for the better, according to those applauding Governor James R. Thompson's recent repeal of premarital AIDS and syphilis testing.

In his September 11 statement to the Illinois General Assembly on signing the repeal measure (H.B.18), the governor urged, "We must respond with compassion and fairness in developing and refining programs which most effectively deal with this disease. The law does not accomplish its purpose and is effectively alienating people from our government, health care and social systems."

Since premarital testing began January 1, 1988, only 52 among more than 250,000 tested were diagnosed as positive. "Required testing of a low risk community, such as those waiting for marriage, is legislative busy work," said Rep. Grace Mary Stern (D-Highland Park), chief sponsor of the repeal. "This bill will put the emphasis where it should be, on voluntary testing."

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Poll says physicians most respected

ILLINOIS DOCTORS rate highest among professional groups evaluated in a recent public opinion survey conducted for the Illinois State Medical Society (ISMS) in late August.

On a zero-to-100 favorability scale, MDs ranked 70.7 percent, followed by manufacturers (63.9 percent), accountants (63.6 percent) and lawyers (55.9 percent).

"It's a very good ranking, obviously," said Robert Teeter, president of Coldwater Corporation, an independent research and consulting firm that directed the survey. "Doctors are seen as a profession doing something for people having a difficult time." He added that while the doctor-patient relationship may have changed over the years, "even the change in health care delivery has not diminished people's respect. The result shows that you can change the system and still maintain the level of respect and admiration."

The poll questioned 800 randomly selected Illinois citizens on a variety of health care issues and the state's current political climate as the 1990 election year contests begin to gear up. The survey's margin of error is plus or minus four percent.

Abortion

Over two-thirds of Illinois voters favor requiring women under age 18 to have parental consent before having an abortion. Fifty-one percent believe public hospitals should not perform abortions unless required to save a woman's life. One half favor using state funds to pay for abortions for women who cannot afford them.

By a 50-37 percent margin, Illinois voters indicated that they would vote for a candidate whose position on abortion was different from their own. Only 26 percent considered themselves "strongly pro-life," and 34 percent "strongly pro-choice."

Forty-one percent favored allowing

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IDPA draft report suggests big Medicaid changes

by Kevin O'Brien



IDPA Director Susan S. Suter

INCREASING physician Medicaid rates, developing Medicaid-provider partnerships in high volume/need areas, and revising reimbursement methodologies are among 44 sweeping recommendations in a potentially controversial Illinois Department of Public Aid (IDPA) report currently being circulated among health care professionals.

The report, issued over IDPA Director Susan S. Suter's name, is marked "draft for discussion," but IDPA furnished it to *Illinois Medicine* because portions had already been made public, according to IDPA spokesperson Jennifer Amdur Spitz.

"It [the report] is a working draft," Spitz said. "The department has not finished putting together what it will propose as its draft . . . it is definitely in the developmental stages." IDPA is now seeking input from provider groups, professional associations, health care reform advocates and other interested parties to determine its final recommendations, according to Spitz.

Spitz said concern about future access to quality care for the state's public aid clients was a major factor in the report's development. "Previous efforts have really been focused on cutting costs, and we'll continue to do that," Spitz said. "But we felt we really needed to focus on access to good quality health care in the future." The department began working on the report in May and expects to release its first public draft later this fall.

Illinois State Medical Society (ISMS) President Eugene Johnson, M.D., said the draft report is currently being analyzed by ISMS. "While ISMS supports IDPA's goal of improved access to quality care for its patients, caution should be exercised to ensure that the changes IDPA is suggesting really meet that goal," Johnson said. "Physicians know better than anyone that this program needs improvement," he said, "and ISMS will work on suggestions to IDPA that will create the best possible program." However, Johnson warned that "change just for the sake of change won't encourage more physicians into the program, and therefore access won't be improved."

The report indicates that the state's Medicaid system is in deep trouble and includes six "core" recommendations that it says should be implemented as soon as possible. It also includes a timetable from October 1989 to January 1992 for implementation of all 44 recommendations.

The report's circulation anticipates the beginning of a promised health care summit announced by Gov. James Thompson, Mayor Richard M. Daley and Cook County Board President George Dunne on August 23. Thompson said that a list of summit participants, whose charge will be to recommend changes in the health care delivery system that serves the medically indigent of Cook County, would be announced "within a few days." However, as of September 19, no announcement had been made and both Thompson and Daley were in Europe.

Chicago Board of Health President Whitney Addington, M.D., said further action was in the hands of the three principals, but added that he was anxious to get going. Dr. Addington said he has been told he will serve on the summit committee that deals with health care policy, and that he hopes it will be an open process. He also said that he had read a copy of the IDPA report and regarded it as a step forward.

Among other things, adoption of the report's recommendations would mean the end of the Illinois Competitive Access and Reimbursement Equity (ICARE) program under which Illinois hospitals are reimbursed. The six core recommendations are:

- The development of Medicaid partnerships in high-need areas to provide community-based, coordinated delivery systems for Medicaid clients, to incorporate quality of care standards, and to develop a comprehensive reimbursement system. The Medicaid partnership would be an "organized network of health care services" sponsored by such organizations as community hospitals or medical centers, freestanding family clinics, community clinics, local government units, or physician group practices. There could be more than one partnership in a given need area.
- The establishment of resource-based reimbursement systems for physician, hospital outpatient and inpatient, and home health services to tie the real costs of care with payment, to put emphasis on preventive and primary care services, and to improve access to care.
- The implementation of social case management in Medicaid partnerships and with special populations such as the elderly, the disabled, pregnant women, children, and persons with AIDS.
- Revisions of the long-term care reimbursement methodology and

(continued on page 17)

Measles fatalities increase

THE CHICAGO Department of Health (CDH) reported September 12 that a 15-month old girl died from measles-related illnesses, bringing the state's total number of measles fatalities to seven. Five of those deaths occurred in the city of Chicago, the state's hardest hit area.

The girl died in late August from pneumonia and septic shock after contracting measles, according to CDH. "Our concern is that this child could have been immunized under our current recommendations lowering the age for measles, mumps and rubella shots to as young as 12-months," said Richard M. Krieg, Ph.D., CDH acting health director.

The spread of measles has slowed in Chicago's most affected areas, bringing the city's total number of reported cases to 1,241 as of September 12. However, Dr. Krieg urged "every Chicagoan who knows the parent of a young child to inquire about the immunization status of that child." To date, more than 50,000 Chicago immunizations have been given. ▲

UI trustees defer plans to approve Reese pact

by Kevin O'Brien

IT WAS A stunning about face.

As the University of Illinois Board of Trustees concluded its Wednesday, September 14 meeting, Board President Charles Wolff told reporters that trustees would follow UI President Stanley O. Ikenberry's recommendation, and vote the next day to approve a master affiliation agreement with the Michael Reese Hospital and Medical Center.

Instead, they reversed course and voted only to adopt a "generic" master agreement to serve as a model for any affiliation the university might undertake. Action on a Michael Reese affiliation was deferred until October when the UI board will consider both a master affiliation with Michael Reese, as well as a subordinate agreement between the hospital and the university's College of Medicine.

Ikenberry's original recommendation had asked the board to approve a "generic" master affiliation agreement, and rescind its April action approving the original Michael Reese affiliation agreement signed in December 1988. This agreement was negated when it failed to win General Assembly approval last June. It also asked the board to approve a new Michael Reese master agreement.

But, during Thursday morning's meeting, secret discussions ensued among university officials, Michael Reese President Henry Nadler, M.D., and some College of Medicine faculty opposed to the vote. The discussions had been prompted in part by a surprise appearance at the

(continued on page 16)



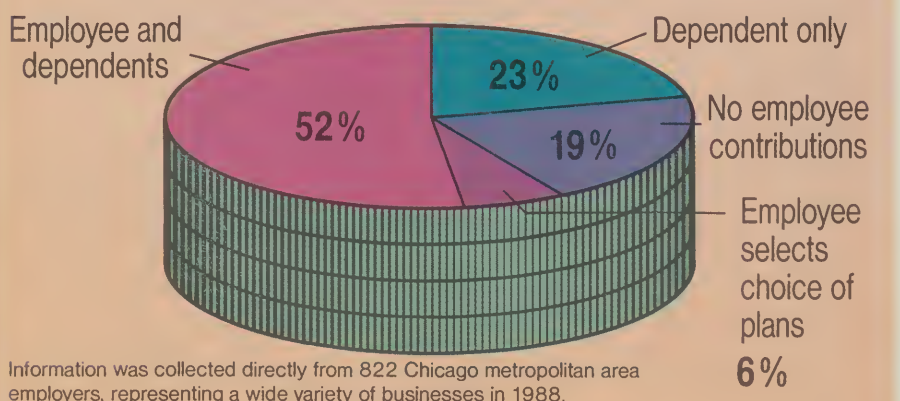
Wm. Daniels/The Photo Partners

State Sen. Richard Newhouse, (D-Chicago), questions University of Illinois trustees on a proposed affiliation between the university's College of Medicine and the Michael Reese Hospital and Medical Center.

Physician Facts

Salaried Employee Medical Contributions

In the Chicago Metropolitan Area



Information was collected directly from 822 Chicago metropolitan area employers, representing a wide variety of businesses in 1988.

Source of Data: Hewitt Associates, Lincolnshire, IL.

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On The Legislative Scene



by Caryl Carstens

Retirement assets protection . . . Governor James Thompson signed into law August 30 legislation protecting physicians' and all Illinois residents' pension assets from creditors in bankruptcy proceedings. The Illinois State Medical Society (ISMS) supported the bill, S.B. 162. "I think it's inappropriate that one malpractice judgment can destroy someone's whole life," said Eugene P. Johnson, M.D., ISMS president.

The governor vetoed September 7 another, more restrictive bill (H.B. 247) that would have excluded from protection the assets of physicians practicing individually or in two-physician partnerships, and of other small business persons who "control" more than half of the employer.

S.B. 162 takes effect immediately.

Abortion . . . At least one attempt to pass abortion limitations upheld by the U.S. Supreme Court will be made when the Illinois legislature returns to Springfield in October. The fall session will be held over a two-week period beginning October 17 and scheduled to end November 2.

Rep. Penny Pullen (R-Park Ridge), hopes to attach to H.B. 574 language nearly identical to the Missouri law on which the court returned a favorable opinion July 3.

"Now legislators would have to vote their conscience" on the abortion issue, Rep. Pullen said. On previous votes on abortion-control bills, legislators were able to argue that they couldn't support unconstitutional legislation.

The Missouri law has three main restrictions Rep. Pullen hopes to duplicate in Illinois, including:

- A ban on performance of abortions in public hospitals or other tax-supported facilities unless necessary to save a woman's life;
- A ban on public employees, including physicians, nurses and other health care providers, from taking part in an abortion procedure unless it is necessary to save life;
- A requirement that medical tests must be performed on any fetus thought to be at least 20 weeks old to determine its viability.

The legislation would not prohibit the performance of an abortion in a private clinic or a physician's office.

H.B. 574, which would require physicians to test for the viability of fetuses believed to be at least 20 weeks old prior to performing an abortion, was passed in different forms in the House and Senate. Rep. Pullen sponsored the bill in the House, and Sen. Richard Kelly, Jr., (D-Hazel Crest) was the Senate sponsor.

A conference committee to work out an agreement was ordered but never met in the closing hours of the spring session, Rep. Pullen said. Right-to life supporters would try to get a meeting of the committee so the new language could be proposed and then presented to the legislature in October. Rep. Pullen is optimistic the legislation can be passed. "We think it will be a truly easy sell," she said.

Rural health . . . legislation aimed at improving access to health care in rural areas generally had little success in winning the governor's approval. S.B. 1302, which would have created a program to award scholarships to people training in the health professions if they agreed to work in an underserved area was vetoed. Thompson termed the legislation "laudable" but said that no start-up funding was provided. He also commented that "the Center for Rural Health established last year and funded in FY90 will assist rural communities [in] defining problems, coordinating resources and developing plans specific to meeting the needs of the area."

Malpractice premium assistance . . . Lack of funding also was the basis for vetoing S.B. 1303, which would have helped obstetricians and family practice physicians to pay their malpractice insurance premiums. While the rural health program as a whole passed the legislature last spring, the votes weren't available to pass funding legislation. There was some hope last spring that the funding bill could be revived and passed this fall.

Incentives for nurses . . . Gov. Thompson also proposed an amendatory veto to S.B. 1304, which would order the state Department of Public Health to determine incentives that might attract nurses to medically underserved areas. The bill, as it was approved by the legislature, would create a pilot program for paying a one-time stipend to nurses willing to work in such areas.

"We're in the process of reviewing those [messages] and we're going to see what we can do," said Sen. James Rea (D-Christopher), sponsor of the Senate bills. Rea said there will be another attempt to move rural health legislation in the new year. "I believe in the spring there will be an emphasis on rural health," he said. ▲

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

REMINDER — WHEN PRESCRIBING HOME OXYGEN THERAPY

The Health Care Financing Administration requires the use of HCFA-484 for *Certification of Medical Necessity for Home Oxygen Therapy.* Forms may be requested by calling (618) 997-3190 or writing:

Blue Cross and Blue Shield of Illinois
Medicare B — Freedom of Information
P.O. Box 992
Marion, IL 62959

The HCFA-484 replaces medically necessity forms now in use for Home Oxygen and ensures that all necessary information is provided to determine whether Medicare payment for oxygen therapy is appropriate. The HCFA-484 will be the only acceptable *initial form* for home oxygen services provided on or after August 1, 1989, and for any *revised* or *renewed certifications* completed on or after that date. Audits have disclosed that medical information has been entered frequently by the oxygen supplier rather than by the attending physician who is legally responsible for the accuracy of the information. Therefore, all entries on the HCFA-484 (apart from the beneficiaries name, address and HICN) must be completed by the attending physician who signs the form or by an office assistant in that physician's employ. The penalty clause (above the attending physician's signature on the back of the form) is incorporated at the request of the Inspector General. No payment for home oxygen can be made unless the attending physician provides satisfactory evidence of medical necessity. ICD-9 codes should be used to describe the patient's condition necessitating the use of oxygen in the home. The date the most recent examination by the attending physician should be entered in item 1.B of the form.

REMINDER — BILLING FOR INTRAOCULAR LENSES (IOL)

When billing for an intraocular lens (IOL) implanted during surgery, be sure to attach an invoice from the IOL supplier. In lieu of an invoice, a statement from the supplier listing the "per lens" cost is acceptable. The invoice or statement must show the supplier's charge to the physician or ambulatory surgical center (ASC) for the IOL. In an ASC, the facility (not the surgeon) is reimbursed for the IOL. IOLs implanted as inpatient or outpatient hospital procedures must be furnished directly or under arrangement by the hospital. If a claim for an IOL is submitted without the invoice, it will be denied.

(This report is a service to the physicians of Illinois)
9/29/89

Editorials

Mandatory premarital AIDS testing: ending an unnecessary burden

Governor Thompson deserves credit for his courageous—and correct—decision to repeal Illinois' premarital AIDS testing law, the lone statute of its kind in the entire nation.

During its tenure, the measure proved to be a tremendous waste of Illinois' health care resources, and achieved meager results. Of 250,000 tests conducted, only 52 positives were uncovered, at an average—and outrageous—cost of $300,000 per positive test.

In April 1988, the ISMS House of Delegates resoundingly voted to work for the law's repeal, on grounds that mass testing on low risk individuals does not prevent the spread of AIDS. Counseling and education are the key to prevention, and should include information regarding all sexually transmitted diseases. ISMS continues to advocate counseling and testing patients when medically indicated or when the patient is known to have participated in high risk behavior.

Migrants' health not just the farmers' problem

Twenty-three thousand or more migrants work on Illinois farms, but live in squalor, with little or no access to health care. Urbanites may regard that situation as remote and the consequences insignificant, but physicians—and citizens concerned about public health—can't afford that irresponsible stance.

The health problems of migrant workers affect every Illinoisan, directly or indirectly. Adequate medical services, including counseling programs as well as preventive health and education efforts, are particularly essential where migrant workers congregate, to assure that serious disease does not spread. Too often invisible in our society, migrant workers have few advocates to speak up for them. But they need and deserve priority for their neglected medical needs. Increased attention to them is good for all of us. ▲

Illinois Medicine

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Guest Editorial

Replying to senior citizens

by Thomas W. Diller, M.D.



Photo: John Cary

I am a young physician practicing in Illinois, and recently read the guest editorial by Gerald Prete of the Illinois State Council of Senior Citizens' Organizations in the July 21 *Illinois Medicine.*

I am a participating physician in Medicare. In fact, I am one of only eight general internists in Peoria County who participate, and thus take Medicare assignment 100 percent of the time. I am not opposed to mandatory assignment being legislated. I also share some of your opinions in regard to the high cost of medicine and its politics.

Your editorial, Mr. Prete, upset me. It contains some inaccurate information, and some cheap shots, which I, as a physician, do not deserve.

In your editorial, you implied that excess charges beyond the Medicare-determined reasonable rate by physicians are too high. You appeared to claim that mandatory assignment would correct this for both participating and non-participating physicians. The maximum amount a physician can legally collect from a patient is what Medicare sets as a reasonable rate. For a non-participating physician, this would be the MAAC. For a participating physician there is also a maximum he or she could collect.

It's true, as a participating physician I can charge anything I wish, but I still can only collect what Medicare allows. It is of note that Medicare routinely pays 80 percent of that figure—whether it is 80 percent of the MAAC, or 80 percent of the participating allowed fee. This is mandated not by physicians, but by the United States government, and, in fact, it is illegal for us to do anything but try to collect the excess 20 percent. Consequently, the absolute most that a Medicare patient should *ever* have to pay for any service is 20 percent of that allowed by Medicare. If a physician or supplier is charging and making the patient pay more than 20 percent, they are committing a crime, and should be turned in to the federal government.

My next problem with your article was your personal attack on physicians, specifically alluding to the fact that family physicians (as well as other primary care providers) do not deserve respect. I resent that very much. I am a primary care doctor. I spend extensive amounts of time with my patients. I am their advocate. Those patients that can't afford to pay my bill often receive breaks. They may have reduced charges, or the level of intensity of service may be decreased. They may receive medication samples at no cost to them, and I frequently talk with them and educate them as to how much certain procedures and tests will cost. My decisions as to treatment often involve a very frank discussion with the patient as to which type of medication they could afford, and together we try to come to grips with treating the patient's medical problems in a manner which they can afford and accept.

There are a few physicians who are milking the system and ripping patients off—not just Medicare patients, but all patients. The vast majority of physicians, however, are quite conscientious, and quite concerned about health care costs. We are constantly asked to work harder, and be paid less for our efforts.

In regard to primary care physicians, even the government says we are underpaid. In fact, the Resource Based Relative Value Scale studies estimate that we are underpaid 20 to 70 percent by Medicare.

I recently looked at the amount of income I would generate in a week's time if my practice was made up entirely of Medicare or Medicaid patients. It's of note that in my particular situation, Medicare pays 67.6 percent of my regular fees. I am, therefore, already giving every single Medicare patient that I see more than a 30 percent discount on my prices. When I factored in uncollectable fees, and subtracted my business expenses (rent, salaries, taxes, malpractice insurance, etc.), I came up with a gross profit of less than what an average factory worker at Caterpillar makes per hour. If all of my patients were only on Medicaid, I would have to borrow over $26,000.00 a year just to pay business expenses before I personally received a dime. I am obviously not becoming rich as a primary care doctor.

Another problem that concerned me was your attack on physician lobbying processes. I despise lobbying. I think it is a terrible way to run a country, let alone a business. Unfortunately, it is the way things are currently done in *this* country. You make it sound in your letter as if all the lobbying is one-sided and done only by physicians. However, organizations such as yours, and specifically AARP, have a tremendous lobbying force both in state and federal government. In fact, they are a feared lobbying force. There are far more senior citizens, and far more financial reserves and votes, than there are physicians.

There is as much, if not more, lobbying going on by various senior citizens' groups, as there is by physician groups. ▲

Thomas W. Diller, M.D. is an internist practicing in Peoria.

Illinois Snapshot

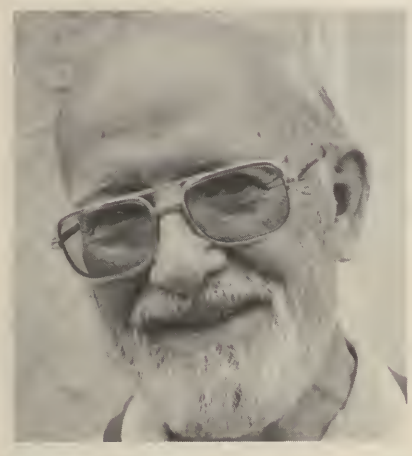
Do you follow your doctor's instructions when taking your prescription medication?*



Jan Schulz
34, of Gurnee, full-time parent
Yes. I assume the doctor knows what he's talking about and he wouldn't tell me not to take it the right way.



Brad Werths
35, of Edwardsville, laser technician
Yes, because that's what I'm supposed to do. When I come upon a situation where they don't seem to be doing what they're supposed to be doing, I contact the doctor.



Robert Graul
77, of Alton, tour director at Alton Museum
Absolutely. Who doesn't? I assume that the doctor knew why he gave it to me.



Tanya Felton
23, of Alton, college student majoring in sociology
Not all the time—and that's the truth. After you get better, it's like, 'Oh, I don't need it anymore,' and you just put it away.



Ann Badasch
38, of Alton, restaurant/antique shop owner
No, I don't follow the doctor's directions. I am incapable of following directions. I have trouble doing what I'm told and I have trouble following directions. I take it when I think about it. I was on medication last month for my foot and I was supposed to take it when I eat. I eat constantly, so when am I supposed to take my medication?



Judi Kass
43, of Granite City, accountant's assistant
Yes, I do. Because I have high blood pressure and I know I'm at risk and I have to. And I take it just exactly the way it says on the prescription bottle.

**based on recent interviews in downstate Illinois. Photos by Maureen Houston.*

Letter to the Editor

Medical Assistants

Organized medicine is beset and besieged by almost everyone these days. Outnumbered, as we are, we should be searching for allies in our struggle for patient care. Yet, under our very noses, is an unashamedly pro doctor group: The Illinois Society of Medical Assistants (ISMA). All employed medical office personnel are eligible to become members. Every office staff should join so medicine's voice can be heard louder and more effectively. Let's challenge ourselves to do more to encourage our staffs to participate in ISMA activities. Working together with ISMA we will maintain quality care for our patients.

Bruce Steffens, M.D.
Moline, Illinois
Chairman, ISMA advisors

EDITOR'S NOTE: For more information on ISMA, contact the Illinois State Medical Society, 312-782-1654.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

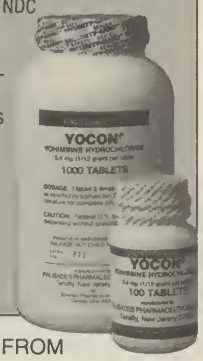
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Retiring policyholders have new options on "tail" coverage

PHYSICIANS who retire, but want to continue using their medical training, knowledge and skills now have the opportunity to do so, as the result of a new policy approved by the Illinois State Medical Insurance Services (ISMIS) on September 6, 1989. The change permits physicians who retire to obtain tail coverage (assuming they meet the "age 55 and five years continuous coverage" requirement for free tail coverage) *and* provide medical care in a free medical clinic and/or work in an administrative capacity where there is no rendering of professional patient services.

Previously, the Exchange prohibited policyholders from obtaining tail coverage if they were going to provide patient care, regardless of the compensation, and whether or not in an administrative capacity. "As a physician owned company, we should do everything within the bounds of what's good business and good medicine to help our physician members and the public," said Robert C. Hamilton, M.D., Chairman of ISMIS.



Rep. Frank Giglio

Will Grundy Clinic

"Two years ago, the Will-Grundy County Medical Society, in conjunction with other community groups, started a free medical clinic," said Stanley Rousonelos, M.D., retired family physician from Will County. "The medical society supplies the primary care physicians for this clinic, each physician spending one day every few weeks. We were upset about physicians not being able to provide free service after they retired, because we have five or six physicians who retired fairly young willing to give one day a month to the free clinic. They were unable to because of their insurance. This new Exchange policy will enable us to use the expertise of these physicians in the free clinic, making it much easier to staff." Dr. Rousonelos has been on the board of the clinic since its inception, and is currently slated to be its first physician chairman.

According to Dr. Rousonelos, during its first year the clinic took care of 1800 patients. "Up until now, if you wanted to retire and do community work, you had to leave the country, and go to a Third World country," said Dr. Rousonelos. "Some of our patients don't have enough money for medical care but don't qualify for public aid. We allow patients to give a voluntary donation. The patient donations in relation to the cost of running the clinic are minute. It gives them a chance to feel like they're doing something."

Medical Practice Act

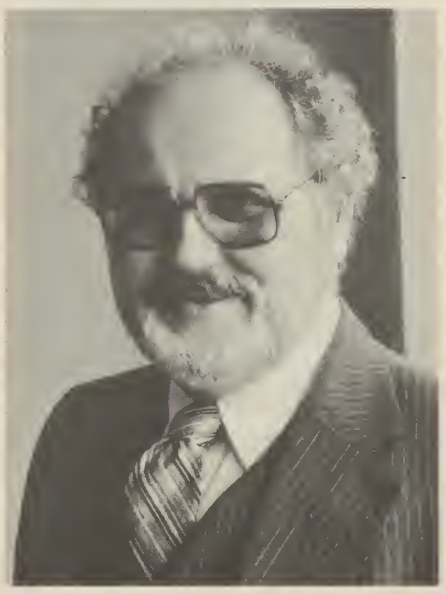
This immunity is available virtually only to retired physicians. The Exchange's new policy takes this into account by allowing practice in a free medical clinic after the free tail is granted. Statutory protection is provided under the 1987 Medical Practice Act for physicians providing medical care in a free medical clinic if the physician receives no fee from the clinic activities or from any other business or professional activity connected with medicine. The exemption does not include a physician's willful or wanton misconduct. Retired physicians who practice in a free medical clinic must also maintain a valid Illinois medical license.

Legislative action

The Illinois State Medical Society (ISMS) supported legislation, sponsored by Rep. Frank Giglio (D-Calumet City) that would grant immunity to physicians who provide services without compensation as part of a community-based free clinic, regardless of whether the physician receives compensation from other patient care activities. The legislation was placed in interim study for reconsideration in the future. "I encourage retired physicians to take advantage of the opportunity offered in the Medical Practice Act to provide free medical care," said Giglio. "However, I want to go further by indemnifying *any* physician who provides free medical care in a community clinic. I will continue these efforts in the future."

Administrative positions

When Sidney Goldman, M.D., a DuPage urologist, retired from clinical practice, he reduced his Exchange insurance classification to the lowest class zero, and gave up active hospital privileges and patient care activities. This Exchange option costs a physician 25 percent of base premium, and was previously the only option a physician could choose in order to do administrative work. Dr. Goldman performs utilization review for HealthCare Compare Corp. in Downers Grove, Illinois.



Stanley G. Rousonelos, M.D.

"The practice of medicine means to me 'hands on'," said Dr. Goldman. "When I do utilization review, I don't make medical judgments that interfere with a physician's style. It boils down to benefits determination. We don't practice medicine. If I'm going to be sued, it's not on a medical malpractice level."

Performing utilization review is just one of the administrative positions a physician can now assume and remain eligible for obtaining Exchange tail coverage. Other positions could be teaching at a medical school, review of medical records on behalf of an insurance company or serving as medical director of a nursing home or health maintenance organization. ▲

High court grants ISMS petition

THE ILLINOIS Supreme Court has granted the Illinois State Medical Society's (ISMS) petition for *amicus curiae* status in the case of *DeLuna v. St. Elizabeth's Hospital and Michael Treister, M.D.* In this case, the first district appellate court, which covers Cook County, had ruled unconstitutional the affidavit requirement for a certificate of merit in a medical malpractice suit.

The Illinois Supreme Court directed ISMS to file a brief by September 19. That brief expresses the reasons ISMS thinks Illinois' high court should accept the case. It also requests the opportunity to file a more expansive brief on the merits of the case, should the Supreme Court justices decide to review the appellate court's decision. The decision on case acceptance could come in early October. ▲

Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If these were your patients, how would you have handled these cases?

Case #1

Presenting case and initial diagnosis—A 48-year-old warehouse worker was sent by his supervisor to an industrial clinic used by the company for treatment of job-related shoulder and arm injuries.

The case in brief—The worker told the examining industrial physician that he was experiencing pain in his left shoulder and arm. He said that a box fell in the warehouse, striking him on the left shoulder, and that he thought he had "pulled a muscle" when he attempted to fend off the falling object. The physician assessed the extent of the man's injuries and recommended that he apply heat, take aspirin for pain and rest the injured extremity. The man left the clinic and drove to his home. Eight hours later he suffered a fatal heart attack.

The resulting claim—The patient's wife and children filed a suit, seeking substantial damages against the industrial physician and the clinic. The suit alleged that the physician failed to take a complete history, do a proper diagnostic workup, diagnose the heart problem, or hospitalize the man after seeing him.

The outcome of the claim—The case went to trial. Even though the patient outcome was bad, the jury found no liability on the part of the defendant physician, apparently accepting the view of an expert witness who testified that the doctor met the standard of care for similar patients seen in an industrial clinic setting. A meticulously documented record also supported the physician's actions.

Case #2

Presenting case and initial diagnosis—A 33-year-old man sought the care of a family practitioner complaining that he had suffered a recent injury which was creating pain in his left arm and shoulder.

The case in brief—The patient told the physician that he thought he had "pulled a muscle" while helping a friend load and launch a heavy boat into the water. The doctor examined the man and found no observable injuries. He suggested application of heat, aspirin, and less strenuous activity until the pain subsided. Five days later the patient returned to the office, complaining that the shoulder and arm pain still continued. The physician again advised the same regimen. He did not hear from the patient again. He learned when he was notified that a negligence suit had been filed against him that the patient had died of a massive heart attack six hours after his second office visit.

The resulting claim—A suit seeking many thousands of dollars in damages was filed by the patient's wife and four small children. The suit alleged failure to properly examine, order appropriate tests, and diagnose a heart problem. During the trial it was documented by the plaintiffs that the man had many risk factors for a heart attack, including high blood pressure, obesity and a history of heavy smoking.

The outcome of the claim—A jury awarded $600,000 to the plaintiffs.

The points these cases make—Consultants make two important distinctions between these two cases, both of which began with indentical complaints. In Case #1, given the problem-oriented setting of the industrial clinic and the history provided by the patient, the care given by the

(continued on page 7)

physician could be supported as appropriate even though death subsequently occurred. Good records kept by the industrial physician also aided in his defense.

In Case #2, the family physician's care on the first visit also could be supported as appropriate. However, when the patient returned for a second time, complaining of continuing pain in the left shoulder and arm, the physician became vulnerable legally for failing to take a more thorough history, for not immediately ordering appropriate tests, and for not making further efforts to diagnose the nature of the problem and to treat it.

Failure to diagnose acute myocardial infarction is a continuing source of costly medical negligence actions. This cause of action is among the top 15 most expensive ones nationally, with average total indemnity payout running over $100,000.

Because an MI can cloak itself in the garb of other symptoms, every physician must be constantly on the alert for the possibility. "If there is any suggestion or question of the presence of myocardial infarction or an impending myocardial infarction, and it cannot be *completely* ruled out, immediate consultation and/or admission is mandated," warned John T. Rogers, M.D., author of the American College of Emergency Physicians *Risk Management in Emergency Medicine Manual.* Four steps are necessary to eliminate the possibility of myocardial infarction, the ACEP manual says:

—Obtain a careful history, including a family history. Is there diaphoresis? Where is the location of the pain? (It can be almost anywhere including the jaw, neck, teeth, ear, etc.) Does the pain radiate? (This too, can vary.) Was the pain associated with activity or stress? Was the patient awakened by the pain? "Most of the minor causes of chest pain will not awaken a patient from a sound sleep," Dr. Rogers says. What does the patient think (or fear) is the matter? Is there a previous history of similar pain? "Very rarely is there no previous history of some pain. It may have been written off as indigestion, a twist, a pulled muscle, many similar things, but there had been symptoms," ACEP's manual emphasizes.

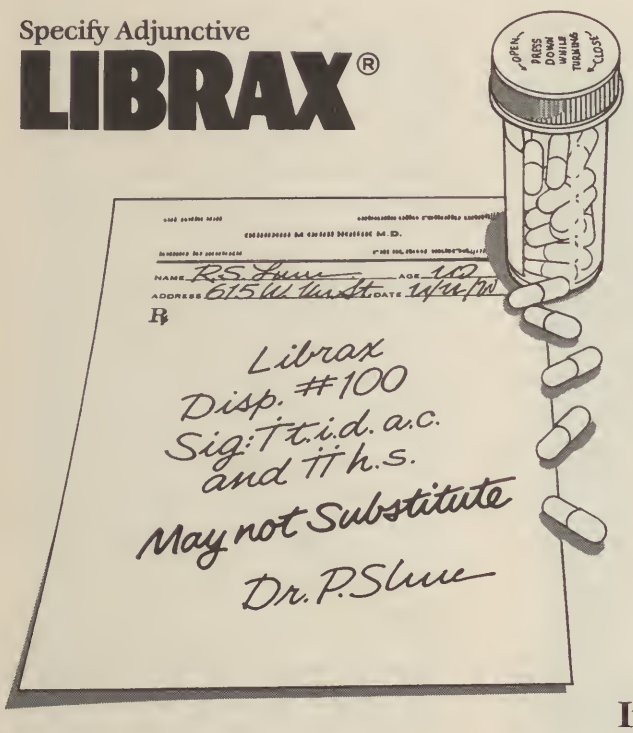
—Evaluate physical findings. The vitals are critical and must be noted and repeated periodically. Presence of PVCs and their location cannot be sublimated, Dr. Rogers notes. What is the patient's general appearance? Does he look ill? Is he extremely anxious? Is his skin clammy to the touch?

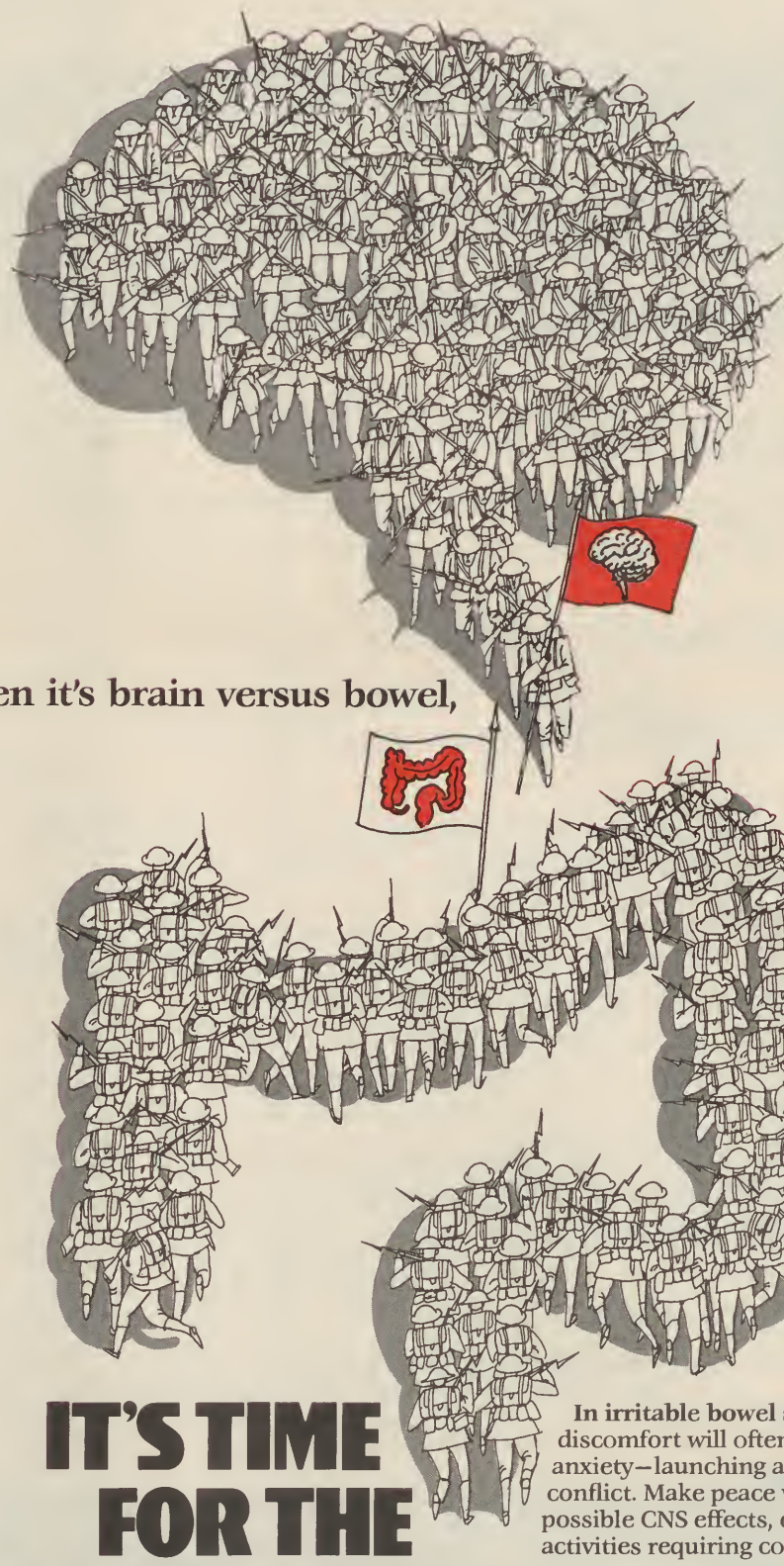
—Order appropriate laboratory tests, including EKGs and enzymes. If tests are equivocal, then the physician must make a clinical judgment call about what is going on with the patient.

—Call for a consult; admit the patient "if there is any question in your mind . . . or you are unable to explain the symptoms or findings in any other way . . ." emergency physicians are advised.

Consultants say that the possibility of myocardial infarction should be carefully considered even when a patient presents with what seem to be unrelated symptoms. In the two cases above, a "pulled muscle" proved to be a far more serious problem. ▲

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Gov. vetoes bill on "off-label" use of FDA-approved drugs

IN A move backed by hospitals, pharmaceutical companies and some physicians, Governor James R. Thompson vetoed H.B. 506, designed to prevent drugs approved by the U.S. Food and Drug Administration (FDA) from being used for unapproved purposes. The practice, called "off-label" use, would also have required informed consent from patients receiving the medications.

Among its most controversial provisions, H.B. 506 would have required the Illinois Department of Public Health (IDPH) to include in its definition of experimental procedures "the use or administration of a drug for a purpose that may not have been approved by the U.S. Food and Drug Administration."

Some health care professionals believe that since off-label prescribing does not depart from accepted standards of medical care, those patients receiving off-label drugs would not be classified as subjects at risk, and therefore, the informed consent provisions would not apply. Others say its passage would have severely constrained current medical practice.

Sponsored by State Rep. Monique Davis (D-Chicago), the measure was passed by both houses of the Illinois General Assembly before reaching the governor's desk. According to Rep. Davis, the bill was spurred by a 1987 incident at Cook County Hospital, where doctors "experimented on pregnant women" in labor with the use of Dilantin, a drug approved by the FDA for epilepsy treatment, but not for other purposes. A Cook County Hospital spokesperson was unavailable for comment to *Illinois Medicine* on the case.



Illustration by Ken Simpson

Patients' rights at issue

The intent of H.B. 506 was "not to stop physicians from experimenting, but to insist that physicians inform patients that an experimental or research project is taking place. People have a right to know their options, or what the results of treatment might be, or what the side effects might be on them and their unborn children," Rep. Davis said.

In his September 7 veto message to the General Assembly, Governor Thompson termed the bill "inaccurate, in that while the FDA does approve drugs, it does not approve or disapprove the uses of drugs." He also noted that the utilization of drugs for purposes other than those included in clinical trials is "a widespread practice."

Physicians' views

The bill's terminology was "unwittingly mischievous," says Armand Littman, M.D., chief of the medical service and a professor of medicine at Loyola University's Stritch School of Medicine, and a consultant to the FDA. "The term 'experimental procedures' sounds perjorative [and] makes it sound like the patient would be used as a guinea pig."

The legislation would also have restricted physicians' freedom to use independent judgment in prescribing medications, Dr. Littman says. "Once a drug is marketed for any indication, it has been the consistent policy of the FDA to permit a physician's discretion to extend the use of that drug for such other purposes as he or she deems wise. It was never the FDA's intention," Dr. Littman adds, "to regulate how drugs were to be used in every situation and all situations. [The] physician's judgment is intended."

Stringent informed consent requirements mandated by the bill are also unnecessary because patients are "already protected by extensive legal structure that keeps a physician from giving capricious, unfounded therapy," Dr. Littman contends.

The measure would have had strong effect on many specialists and subspecialists. "Every oncologist I talked to in the state immediately got a red flag," recalls Joseph Katterhagen, M.D., executive director of the regional cancer center in Springfield's Memorial Cancer Center. "Sixty percent of the chemotherapy used on a day-to-day basis in Illinois and across the United States is off-label, not specifically licensed for use against a specific cancer." Enactment of H.B. 506 would have created a "tremendous bottleneck and cost," he explained. "If I tried to use a drug like Cytoxan in my office, and had to get signed consent from patients, it would be overwhelming." The informed consent requirement would also have had a heavy impact on hospitals, he adds.

"We told [the governor] that enactment would be unnecessary, confusing and possibly costly," says Kathleen Dunn, senior director of government relations at the Illinois Hospital Association, in Springfield. Another harmful aspect of the legislation, she contends, "could be the refusal of insurance companies to pay for drugs for a purpose that may not have been approved by the FDA. Insurance companies don't reimburse patients for [drugs used in] experimental procedures, so including unapproved uses in the definition could result in increased numbers of rejected insurance claims, and the cost would have to be absorbed by patients."

Pharmacists say law unneeded

A spokesman for the Illinois Pharmacists Association agreed. "Laws on the books are specific enough [regarding] informed consent," and the fact that hospitals have institutional review committees to approve and oversee experimental protocols obviated the need for additional state law, according to Ed Halstead, interim executive director of the 2,500-member organization.

Obtaining FDA approval for new application of an existing drug is lengthy and burdensome, commented John Snyder, president of the Illinois Council of Hospital Pharmacists. "It's hard to provide the large amount of data FDA requires, and it's a burden on drug companies to submit the paperwork. If they already have the drug approved, and don't see a big market for a new application, they may not pursue it," he said.

Rep. Davis is looking forward to the General Assembly's November veto session, for another opportunity to get H.B. 506 on the books. "I'll be working to override that veto. If there are certain things [in this bill] they'd like us to put in or take out, we'll certainly consider it, to make people as happy as possible with the legislation." ▲

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Physicians should talk more to patients about medication, says advisory group



SPEAK UP AMERICA
Talk About Prescriptions

"PATIENTS are generally well treated, but, a lot of the time, they don't understand enough about the medicines physicians prescribe to them. We, as health professionals, must try to communicate to patients more effectively," said David Morse, M.D., a general internist in Urbana.

That's the hope of the National Council on Patient Information and Education (NCPIE) as it gears up for its fourth annual "Talk About Prescriptions" month in October. NCPIE is a 250-member coalition of health professional societies, consumer organizations, government agencies and voluntary health organizations.

"We are calling upon physicians and other health professionals to help spotlight the problem of medicine misuse and provide opportunity for individuals and health organizations to become more involved in the special needs of all Americans who use prescription medicines," said NCPIE spokesman Ray Bullman.

Nearly 33 percent of patients nationwide receive no information on prescription medicine from physicians and pharmacists, according to the U.S. Food and Drug Administration. But 96 percent of patients never ask any questions about their medicines.

This year's theme, "Speak Up America: Talk About Prescriptions," is also geared towards improving communication about medicines among families, according to NCPIE Chairman Paul G. Rogers. "The first step is for families to make proper medicine use a family health priority, like proper nutrition or good hygiene. Parents need to talk to their children about safe and effective medicine use, starting in pre-school years and continuing as the children grow, especially in the teenage years. They should also talk to their older parents who may be using several medicines to help them avoid the special problems older people can have with medicines," added Rogers.

Although individuals 60 and over comprise only 17 percent of the total U.S. population, they account for 39 percent of all hospitalizations and more than half of the deaths from adverse drug reactions, according to NCPIE. Moreover, the lack of effective communication between older people and their physicians is a major contributing factor to medicine misuse, according to a 1987 NCPIE report.

"Some elderly are very compliant in taking their medicines properly, but often times, someone else is putting out their medications for them, and that person may forget or not be home," said David J. Hagan, M.D., a family physician in Gibson City. "I have an elderly patient on nine different drugs every six hours, mostly for her heart. In order to keep all the pills and doses straight, she must rely on her granddaughter. Once, we learned she hadn't taken any of her medications for the day because her granddaughter wasn't home. That's why it's so important for physicians to remind and encourage older patients to bring their pills to their appointments so we can go over them and make sure they take them properly, or it can be very dangerous," Dr. Hagan said.

But elderly people aren't the only ones improperly taking their medications. In fact, two out of every five patients skip their medications or take "holidays" from their prescriptions without the physician's or pharmacist's consent, and nearly half of all patients take too much, too little or none of their medicine, according to NCPIE.

"If doctors can't afford the time to go over the patient's medications and their possible side effects, physicians' assistants could really be of great help by taking the time to explain each medication. This ought to be done in more doctor's offices," said Dr. Morse.

"Today, the general public is much more intelligent about medication and their own health care. Twenty or thirty years ago, the medical profession had more of a tendency to withhold information about medications from patients because of concern they would get confused or worried. An example of this is the *Physician's Desk Reference (PDR),* which lists all prescribed medications with dosage indications and side effects. Back then, we really kind of secretively guarded that book because we didn't want people reading details about the possible side effects. Today, anyone can purchase a *PDR* in a bookstore."

Physicians can participate in "Talk About Prescriptions" month and obtain a planning guide with promotional materials and ideas to highlight office activities by calling NCPIE at (202) 347-6711. ▲

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Photos by James A. Laughlin, Illinois Migrant Council

Migrant workers face barriers to health care

EACH YEAR, a predominantly Spanish-speaking population consisting of about 95 percent Mexicans leaves their homes in Texas to work the farms of Illinois. Many are descendants of migrant farm workers who replenished much of the state's agricultural force during World War II when farmers were called to duty. Today mother, father, sister and brother, even grandparents continue to work side by side harvesting the fields of asparagus, corn and potatoes in Princeville, and apples and peaches near Carbondale.

According to a 1988 study contracted by the federal government, there are roughly 23,000 migrant farm workers in Illinois. James Laughlin, Illinois Migrant Council (IMC) health services director points out, "Because of their mobility, it is difficult to accurately assess just how many migrants there are."

However, groups dedicating years to assessing the needs of migrant farmworkers agree migrants are often hindered in seeking proper health care because of social, economic, linguistic and cultural barriers. Laughlin adds, "They and their children experience extraordinary rates of certain diseases including hypertension, diabetes and many infectious and acute problems related to their unhealthy living conditions." According to an IMC 1988 study, the most common health problem among migrant workers at all service sites was upper respiratory infections. Other diseases commonly found were conjunctivitis, contact dermatitis, musculo-skeletal complaints and tuberculosis. The study also revealed that among 170 farm workers screened for tuberculosis, 28 tested positive and needed further diagnosing and treatment as necessary.



"Because farmworkers do not benefit from worker's compensation and there are minimal protective regulations and legislation for them, farm owners have no incentive to improve conditions to reduce the risk of injury or disease," says Laughlin. He adds, "Our strategy for this year is to focus on educating the migrant family on measures they can take to minimize the spread of infectious disease among them. We are also trying to encourage full compliance with field sanitation and migrant labor camp regulations, in addition to expanding our program of screening and follow-up for tuberculosis and other serious communicable diseases."

Pesticides pose problems

Fernando Almanza, a migrant worker at H and E Sod Farm in Momence and chairman of IMC's board of directors, has no complaints of his farm, but says two of the biggest problems other migrants face are inadequate housing conditions and pesticide use. "Plants are always being sprayed with pesticides. Farm workers suffer from bad skin and eye irritations, along with stomach and lung problems from being exposed to pesticides. It gets worse when there's inadequate field sanitation," he says.

On some Illinois farms, including the H and E farm, "pesticide application is not done by farm workers, and herbicides are sprayed long before workers even touch the sod," says H and E Sod Farm owner Dale Habenicht. However, physicians who treat migrants working with crops such as asparagus say a common problem they see among farm workers is skin inflammation of the upper arm largely due to pesticide exposure.

"While highly toxic pesticides are restricted to use only by certified applicators, some of the most hazardous types of compounds in soil and insecticides are widely used by migrant workers, particularly in Illinois for corn and root worm control," says Robert Metcalf, Ph.D., professor of entomology and environmental studies at the University of Illinois in Urbana.

"I spent eight years on a pesticide scientific advisory panel. We had numerous representation from migrant



workers all over the country who had concerns about poisoning themselves because of ignorance. They are notorious for not being able to read the labels written in English to understand the hazards," Dr. Metcalf says.

"Unless the pesticide poisoning is severe enough to make them unable to work, many times migrants regard the sickness as food poisoning or the flu," adds Tom Long, Ph.D., senior toxicologist at the Illinois Department of Public Health (IDPH).

Dr. Long says acute poisonings from pesticides are becoming rarer because of stricter federal guidelines. However, "when certain compounds in pesticides penetrate the skin, they can inhibit a specific enzyme that is very fundamental to proper nerve impulse transmissions in both insects and man. Prolonged pesticide exposure can also cause lack of coordination, tremors, allergic reactions, vomiting and convulsions," adds Dr. Metcalf.

"Almost all migrants are denied Medicaid or public assistance because they earn more [here] and usually have two or more workers in the family."

IDPH is working toward efforts to increase the penalty for farmers violating pesticide use by increasing the current fine from $100 to $500 and adding the possibility of six months' imprisonment.

Poor housing conditions

IDPH annually inspects some fifty migrant labor camps licensed in Illinois, for general housing conditions including electricity, water, fire safety, sewage disposal and general sanitation of the units. Licensure is required for farms housing four or more migrant families or ten individual workers.

Almanza attributes more health problems among migrant workers to overcrowded living conditions. He says many bi-level units house an average of twenty workers.

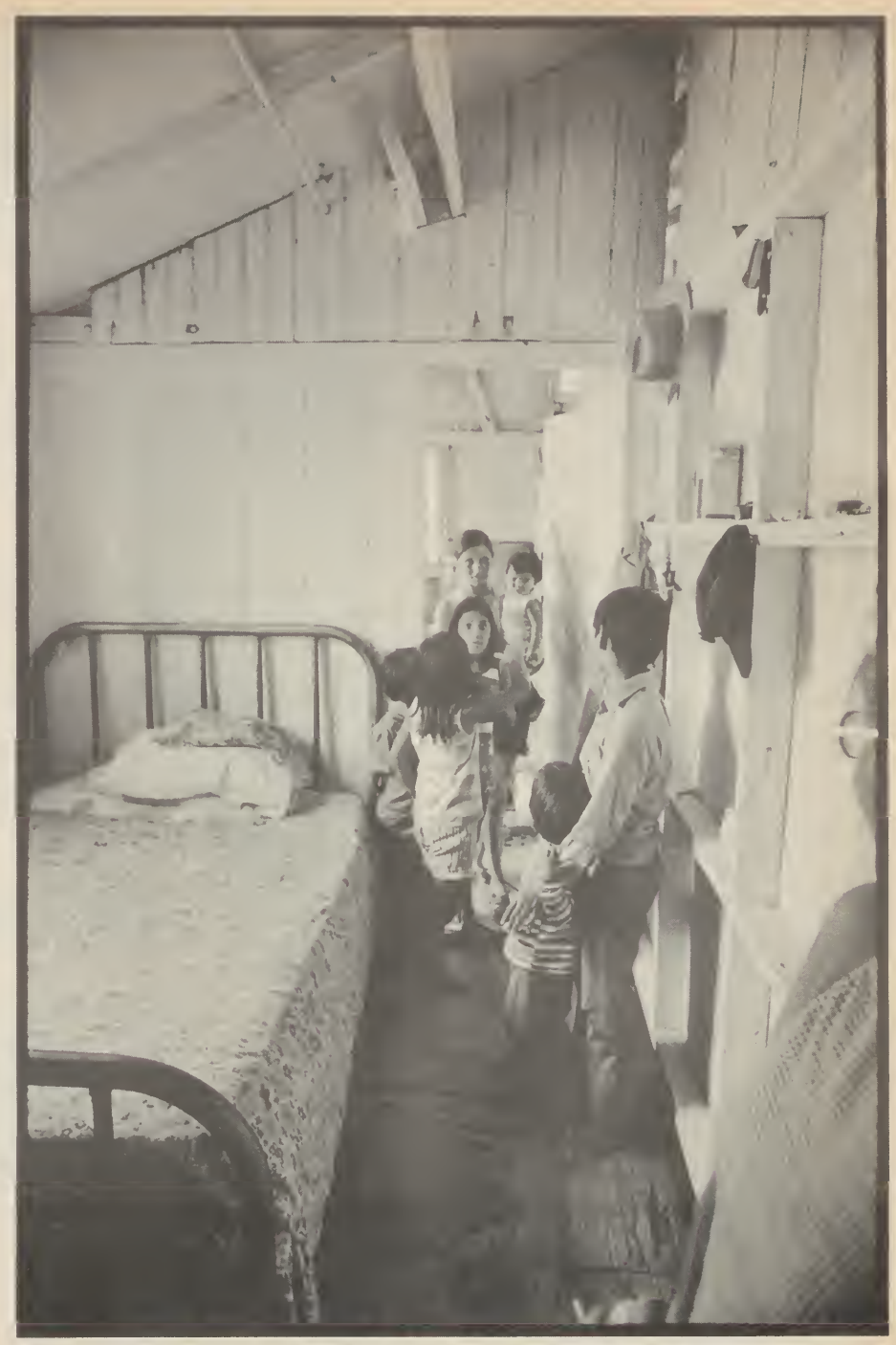
"Although our standards are minimum, they do protect the health and safety of the migrant. However, many times it's difficult to determine where these locations are. Farmers sometimes rent houses to workers and we aren't aware of it until we get a complaint from concerned community organizations," says Pat Metz, chief engineer of IDPH's environmental health department.

Health care services

Illinois migrant farm workers are provided health care services through IMC's federally funded health project. IMC staffs nurses in scattered rural migrant locations throughout the state. When further medical assistance is needed, IMC contracts with local physicians, and migrants are referred to private practitioners. Half of all pharmacy prescriptions, lab and x-ray costs are paid for. However, migrants are required to pay a two-dollar co-payment for each physician visit. When in-patient hospitalization is required, IMC assists migrants in finding alternative payment plans.

According to an IMC study, 94 percent of all Illinois migrants are below the poverty level. "Almost all migrants are denied Medicaid or public assistance because they earn more in the Midwest than at their home base and usually have two or more workers in the family. When hospital bills are high, migrants who do qualify for Medicaid have large 'spend-downs' and often must pay more than two-thousand dollars before they are assisted," says Laughlin.

"I don't feel there's sufficient funding to provide total health care for all Illinois migrants and there's a fair chance we may run out of money in October or November. Because many of the farm workers are dispersed in small migrant labor camps and scattered housing, the outreach, follow-up nursing care, translation, transportation and utilization of health care referral networks all contribute to a higher cost per person than might be found at the typical community health center," Laughlin adds.





More physicians needed

There are not enough clinics and physicians devoting time to treating migrant workers, according to Fred White, M.D., Chillicothe. Over the years, Dr. White has developed a program at Princeville Medical Center that has helped thousands of migrants. Dr. White says he gained interest when his nurse "took her station wagon to a migrant camp." What began as an informal transport service soon mushroomed into a much-used, and much-needed, treatment system at the camp. "Later, we decided to set up this program," says Dr. White.

Physicians target problems

Migrants generally suffer from illnesses common to the rest of the population in addition to "problems stemming from the nature of their work, such as dermatitis because of their exposure to pesticides," according to Mike Jongerius, M.D., of Princeville Medical Center. Silvia Z. Panitch, M.D., points out a large number of migrants also suffer from diabetes because they are Hispanic. She says diabetes is more prevalent among Hispanics because of heredity, obesity and diet.

Dr. White says one of the biggest problems in treating migrants stems from "their lack of knowledge in seeking preventive health care. Many do not believe in doing things for their health now, to prevent something from happening to them in 20 years. Their only concern is for tomorrow." He adds, "Unless they are absolutely sure that something is wrong, they are not anxious to seek medical attention. Going to the doctor doesn't mean just taking time out of the day, it means taking money out of their pocket."

Dr. Jongerius says there is a need for a better communication network between all facilities treating migrant workers to organize a more efficient medical records file. "We spend so much of our time trying to coordinate what's already been done in other places. Unless migrants have good insight into their health problems, there's a lot of repeated blood work and exams that have already been performed. That's to nobody's benefit."

In speaking of why physicians should help migrant farm workers, Dr. White says, "Doctors should recognize that whatever we do isn't just for money. A lot of the time, it's for humanity or because there's a need out there. Treating migrants takes a little more time and doesn't pay as well. But it's a very gratifying activity because the people are appreciative. I have a soft place in my heart for migrants. Generations have reappeared on these farms and some of the children I've seen grow up here are now graduating from nursing schools. They've become solid respectable citizens." ▲

(continued from page 1)

fessional affairs at the Illinois Hospital Association (IHA).

According to IDPH regulations, level 1 trauma centers must be staffed by in-house general or trauma surgeons available 24 hours a day. Surgeons must be available within 30 minutes at level 2 trauma centers. Several other criteria exist, as well, for various levels of trauma center designation.

Rockford hospitals divided

In an already highly competitive region, heavy financial losses have engaged Rockford area hospitals participating in the trauma network in what is "perceived by the community as an all out war." Rockford Memorial Hospital is on one side, and St. Anthony and the remaining hospitals on the other, according to Debra Wilson, administrative manager of St. Anthony pre-hospital and trauma center.

The problem began when area hospitals accused Rockford Memorial of delaying submission of a regional plan required by IDPH for all hospitals involved in the network. The plan would detail how the region's system would run. Region 1, which includes the Rockford area, initially submitted its plan to IDPH in early May. However, Rockford Memorial Hospital disagreed with the plan, requesting that IDPH include into the plan a "by-pass policy."

The policy would help recoup Rockford Memorial's level 1 costs, while unnecessarily steering patients away from treatment at any level 2 trauma centers, according to Michele Ziglar, trauma network coordinator for SwedishAmerican Hospital, a level 2 trauma center. Rockford paramedics presently route trauma patients to the nearest hospital, regardless of level. "A bypass policy would require paramedics to route patients directly to a level 1, if they meet level 1 trauma criteria, automatically bypassing any of the region's five level 2 hospitals," argued Ziglar.

"Even if a patient was in a car accident in Belvidere, about 15 minutes from SwedishAmerican Hospital or on Charles Street, right along side SwedishAmerican, paramedics would automatically have to bypass us and go directly to a level 1," Ziglar said.

Level 1's must agree

According to IDPH, both of the region's level 1 hospitals must agree on the plan or the department will designate one plan for any region failing to do so, said Jim Stone, IDPH trauma project coordinator. "At this point, they [region 1] do not have an approved plan and are still in a working phase," he said.

Rockford's St. Anthony Medical Center, the other level 1 trauma center, was first to be granted that status in 1971, 17 years before Rockford Memorial. "That gave them the opportunity to market themselves over that period of time to pre-hospital care providers and to other hospitals in that region so they have established a solid referral pattern," said Art Proust, M.D., co-director of trauma services at Rockford Memorial. "Disagreeing with the other area hospitals would not be a politically good move for them," he added.

In early September, region 1's trauma network board re-voted 19-2, again favoring submitting the original plan without a bypass policy. The two dissenting votes came from Rockford Memorial.

"There are certain time constraints where it would not be feasible for a patient to go to a level 1, said Dr. Proust. "But if the accident does happen within a reasonable distance and the patient meets certain criteria provided by the American College of Surgeons, patients would benefit by being bypassed to a level 1 trauma center." He added, "The rest of the region does recognize the different levels of capability between hospitals, but has not put in what we feel is an appropriate hospital bypass policy."

Dr. Proust said Rockford Memorial will maintain its level 1 status. "However, there is a certain financial obligation that goes with that. If patients are triaged appropriately, certainly some of the revenue generated will help meet some of the costs required for being a level 1."

"We mean business," responded Ziglar. "Rockford Memorial is attempting to take our trauma business away from us and if this is passed, we've already told them we'll file suit for restraint of trade," she said.

Guidelines too lenient

Trauma experts criticizing the network are pointing a finger at IDPH. "I don't think anyone believes you can put a system together to provide trauma care and do it absolutely correctly from the beginning," said Gary Merlotti, M.D., a 15-year veteran in trauma business and director of Christ Hospital's trauma services in Oak Lawn. "However, IDPH has done very much of nothing toward solving the existing problems. They put the network in place and said, there it is, go with it."

Dr. Merlotti blamed Rockford hospitals' revenue losses on lenient guidelines. He argued for more stringent trauma network guidelines limiting the number of hospitals in any one region. "Rockford's few hundred patients treated each year, according to the American College of Surgeons, aren't enough to justify having even one level 2 trauma center. But, they've got two level 1's and a level 2 just in Rockford. Until IDPH irons out these problems, they're going to maintain these problems," he said.

Dr. Merlotti urged IDPH to look at what has resulted from Chicago's trauma system. "The city needs to limit the number of trauma centers even further. Infant mortality rates are exceedingly high at hospitals that don't get adequate volumes of trauma patients, and are much lower at hospitals which treat large volumes of emergency patients. Because things happen so quickly in trauma care, it is essential that the team perform trauma care over and over, so it becomes second nature, automatic. If a hospital is only seeing 50 or 60 patients a year, it will never get to the point of providing care properly, no matter who it is or how good it is."

Participation is voluntary

IDPH officials said hospitals throughout the state had input into the network's design before it was enacted. "Some hospitals feel that the cost is worthwhile and are willing to participate. Participation in the network is voluntary. The three Rockford hospitals got involved because they wanted to," said Tom Schafer, IDPH spokesman. "But we don't believe that many hospitals [involved in the trauma network] are necessary for [Rockford's] type of community," he said.

John Lumpkin, M.D., associate director of IDPH's office of health care regulations, said the department is, "Still trying to work out some of the system's bugs, but the intent of the network rules is to assure all involved parties have input into how patients are distributed." He emphasized, "the issue of hospitals setting triage criteria is, at this particular point, a local, regional issue."

IDPH is currently implementing a trauma registry, a data gathering system that collects information on trauma treatment and injuries. Trauma centers are required to submit the report at the end of their first quarter. About 60 of the 76 centers have completed first quarter participation in the network.

"We don't know whether we are going to see clear trends or if we are going to have to collect three or four more quarters' worth of data to begin seeing trends that are statistically significant," said Dr. Lumpkin.

The Illinois State Medical Society (ISMS) will work with IDPH to allow for greater flexibility by "limiting the designation of trauma centers to a number appropriate to meet the trauma needs in the state and to establish an efficient system of trauma care," as stated in ISMS House of Delegates Resolution 36 (A-89). ISMS is now studying just how to repair the problems.

"Physicians in the network are finding themselves very polarized. We're supposed to act as patient advocates, but it's difficult when, at the same time, we're involved with the system's problems," said Robert Bertrand, M.D., president of the Winnebago County Medical Society. "Putting financial considerations aside, when it comes to caring for patients, surgeons are terribly dependent on hospitals. When it comes down to a crunch, it's very hard to turn your back on a hospital that provides you with a place to take care of your patients."

Fewer problems

Hospitals elsewhere in Illinois that are part of the statewide or Chicago trauma systems report only some of the problems Rockford faces. Officials at level 1 Christ Hospital in Oak Lawn affirmed their institution will remain in the network. "We're not losing our shirts yet. While trauma is not a profitable service at the hospital, we feel it's within our philosophy to continue to provide this kind of service. However, involvement in the trauma network has made it necessary for a hospital emergency room expansion project that will allow for additional intensive care unit beds," said Dr. Merlotti.

Factors in financial losses

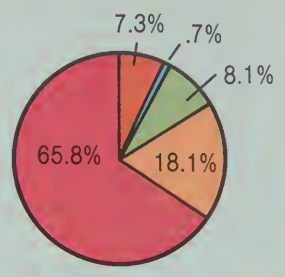
At SwedishAmerican Hospital, in Rockford, 31.7 percent of trauma

Who Pays for Trauma Patients?

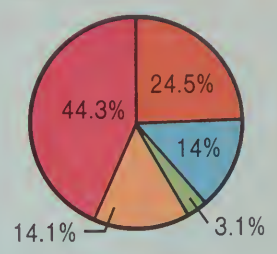
Public Aid-Medicaid · Self-Pay · Workman's Compensation
Commercial Insurance · Medicare · Other (includes HMO)

Mt. Sinai Hospital, Chicago (in 1988)

Trauma

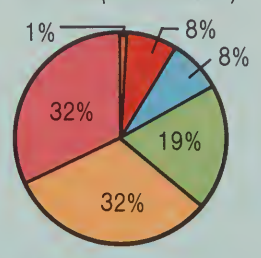


Non-Trauma

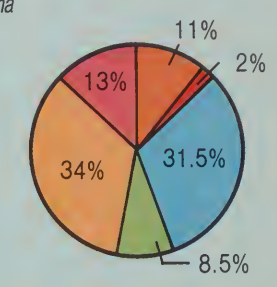


SwedishAmerican Hospital, Rockford (June 1, 1988–May 31, 1989)

All Patient Admissions (includes trauma)

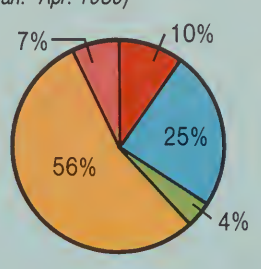


Trauma

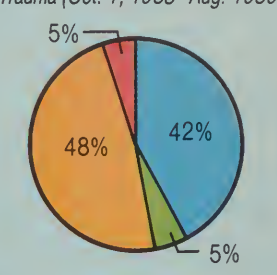


Saint Anthony Medical Center

*Trauma (Jan.–Apr. 1989)**



Non-Trauma (Oct. 1, 1988–Aug. 1989)



* Figures provided by St. Anthony Medical Center. Total slightly more than 100%.

Source of Data: Mt. Sinai Hospital, Chicago, SwedishAmerican Hospital and Saint Anthony Medical Center, Rockford

patients are public aid recipients. Thirty-two percent have commercial insurance, 19.5 percent are self-pay, 7.8 percent have Medicare, 7.8 percent have workers compensation and 1.1 percent are designated as other.

At Mount Sinai Hospital in Chicago's trauma network, treatment of trauma patients costs are more than double that for non-trauma patients. The hospital suffered losses of nearly six thousand dollars for each of its 149 trauma patients admitted during fiscal year 1988. Those patients rang up a total of nearly $3.5 million dollars, for which the hospital was reimbursed less than half. Forty percent of the patients had no medical insurance and although public aid covered some of the patients, state reimbursement totaled less than half the cost of serving them, according to the hospital's trauma profitability report.

"Because things happen so quickly in trauma care, it is essential that the team perform trauma care over and over, so it becomes second nature, automatic."

Loyola leaves Chicago network

High cost is just one factor concerning participants in the Chicago emergency trauma network. While still remaining in the state network, Loyola University Medical Center, one of the busiest trauma centers in the nation, will drop out of Chicago's system October 1. It is the third hospital to leave the city's network in the past 18 months. The University of Chicago Hospitals and Weiss Memorial left the trauma network last year.

"The 150 percent increase in trauma patients in the past three years has literally played havoc with our schedule," said Michael Maggio, Loyola's public relations director. This has not only had a stressful impact on the emergency rooms, but on ancillary services and other areas such as surgery operating rooms and radiology. We've also had to postpone elective surgeries for non-trauma patients because of the influx, and radiology has had to go to 24-hour staffing."

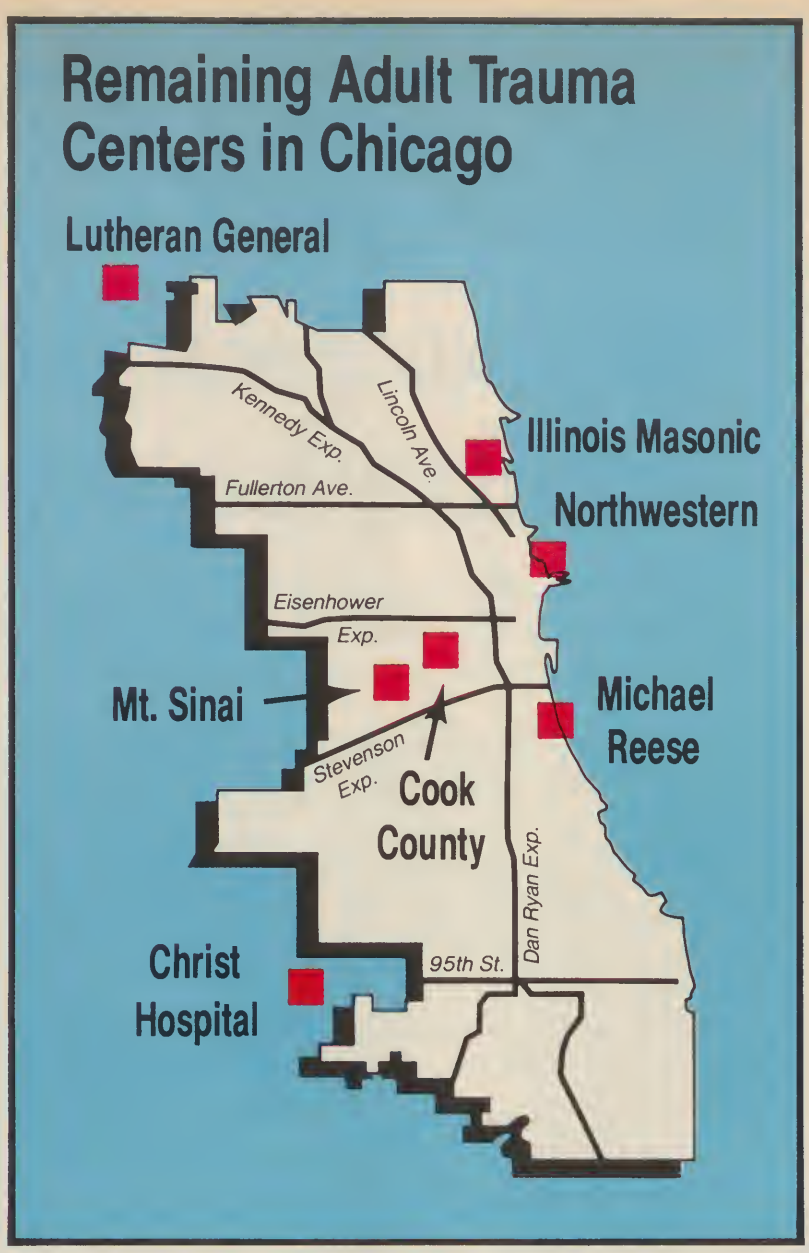
Loyola is the only level 1 center for 1.75 million people in suburban Cook and Du Page counties. About 80 percent of its trauma patients live outside of Chicago, according to Maggio.

Picking up the slack

Health officials predict Chicago patients who would have gone to Loyola will be routed to Mount Sinai and West Suburban Hospitals. Norman B. Goodman, president of West Suburban Hospital in Oak Park declined to comment on the situation.

Phill Zaret, M.D., director of trauma services at Mount Sinai said, "We're sure we can handle the spillover from Loyola. It should increase our volume to some extent, but certainly it will not overburden our system. Most of their trauma is coming from the suburbs, not from the city."

Loyola treats about 70 of the city's approximately 1300 trauma patients annually. However, "we estimate we receive about 50 [in addition to the 70] less severely injured trauma patients that can be taken to other hospitals," said Maggio.



"Loyola's departure is a signal that there are difficulties that need to be responded to," said Richard M. Krieg, Ph.D., Chicago Department of Health acting health commissioner. In mid-September, Dr. Krieg met with chief executive officers of each of Chicago's trauma centers. "We had a very constructive discussion regarding the Loyola situation as well as other issues. I'm confident we can move towards resolutions of some of the problems and that they will be perceived within the context of overall health system reform," he said.

"One of the assets we now have is that the mayor, governor and county board president have agreed to work together in what they called a health summit, designed to address issues such as the trauma network," Dr. Krieg added. "Chicago and the state's trauma concept do not align and we feel it's necessary to have a better understanding of how the two systems interface. The ongoing meetings will address issues of discontinuity between the city and state systems, finance questions and certain operational problems that ought to be reviewed in a forum at that level."

Chicago's Michael Reese Hospital announced its withdrawal from the city network last November, but later remained because of prospective affiliation talks with the University of Illinois Medical School. The affiliation never occurred and a Michael Reese spokesperson said the hospital is now reassessing its involvement with the network trauma system.

Network needs improvements

Meanwhile, those remaining in the network are looking at ways to improve the system. "IHA will recommend to IDPH that level 1 hospital physicians in rural parts of the state be on-call rather than in-house. This will reduce some of the costs associated with the expense of the staffing requirements," said Damasauskas.

"Because of the distances in transporting a patient in certain circumstances outside the metropolitan area, physicians could be on call and would be able to get to the institution within a half hour, before the patient arrives. Even after the patient arrives, there are certain procedures that must be performed in order to prepare patients for the physician's work," he said.

Damasauskas maintains the only solution to improving the system is increased funding. "Chicago has the same problems that southern California or Florida have in trying to maintain an effective network. There needs to be some form of minimal insurance allocated to trauma patients who largely don't have insurance," said Damasauskas.

"The solution isn't funding," says Dr. Merlotti. "It's putting together a system that will work and then funding it. No matter how much funding is supplied to the hospitals in Rockford, if there are three hospitals trying to divide a limited number of patients a year, none of them are going to take care of those patients properly." ▲

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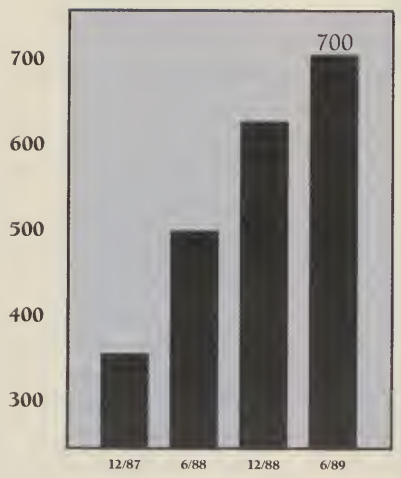
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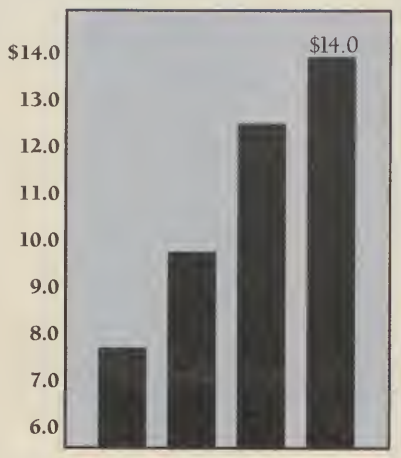
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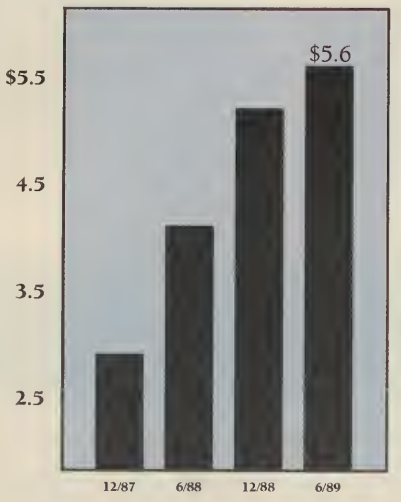
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ASSOCIATED PHYSICIANS INSURANCE COMPANY

AIDS testing

(continued from page 1)

Illinois State Medical Society (ISMS) President Eugene P. Johnson, M.D., said of the governor's action, "It took courage, and sound weighing of the issue on its merits. Mass testing does not prevent the spread of AIDS. Counseling and education do. ISMS worked hard for repeal of premarital testing," he added.

The governor emphasized that mandatory testing will be replaced by a requirement that each county clerk's office distribute brochures about AIDS and sexually transmitted diseases (STD) to individuals planning to marry.

"People who may have engaged in high risk behavior should start their marriage with the knowledge and understanding of their health status and take that opportunity for HIV counseling and testing," said Penny Strong, Illinois Department of Public Health spokesperson.

Opponents of the repeal expressed disappointment with the governor's action. "Although it's a low risk group, any people we can identify and then hopefully care for, is important," said Sen. Frank Watson (R-Greenville).

In support of his repeal, Governor Thompson also cited the decline in marriage applicants seeking Illinois licenses. Lake County Clerk Linda Hess blames premarital AIDS testing for some $15,000 in revenue losses. "There is no doubt that couples seeking to marry traveled just north to Kenosha County for their licenses to avoid paying the premarital AIDS fee. Since the repeal, we've had at least 20 percent more calls coming in just in the last two days," Hess said.

Meanwhile, Lake County is reviewing its staffing situation in anticipation that the new law will reinstate the higher number of marriage applicants, according to Hess.

Repeal of premarital AIDS testing was only one of several AIDS related bills included in some 1,200 the governor reviewed before his two-week European business trip.

Among those the governor signed was H.B. 1876, sponsored by Rep. Penny Pullen, (R-Park Ridge) and Sen. Watson. The bill allows the state to enter into a contract with one or more labs to assure high quality HIV testing at the lowest cost. It also requires IDPH to make AIDS statistics available to the public by the 30th day of each month, including those of prospective Illinois residents tested by federal agencies. It requires Department of Alcoholism and Substance Abuse treatment centers and sexually transmitted disease clinics to offer HIV testing to clients.

ISMS opposed passage of H.B. 1876. "It is questionable whether other reporting categories would be helpful in stemming the spread of the HIV, since the major groups at risk are already included in the statistics. It also makes little sense to have the state contract with any other lab when the state already has a high quality HIV testing facility," said Harold L. Jensen, M.D., ISMS chairman, in a letter to the governor.

The governor eliminated a provision in H.B. 1876 which would have required the Department of Corrections to perform AIDS testing on all inmates 15 days prior to discharge. The bill takes effect July 1, 1990.

Also signed by the governor, legislation reinforcing AIDS patients' confidentiality. The bill, H.B. 2362, sponsored by Rep. John Cullerton (D-Chicago) and Sen. Arthur Berman (D-Chicago), makes violators guilty of a petty offense and fines them $1,000. The law is effective immediately.

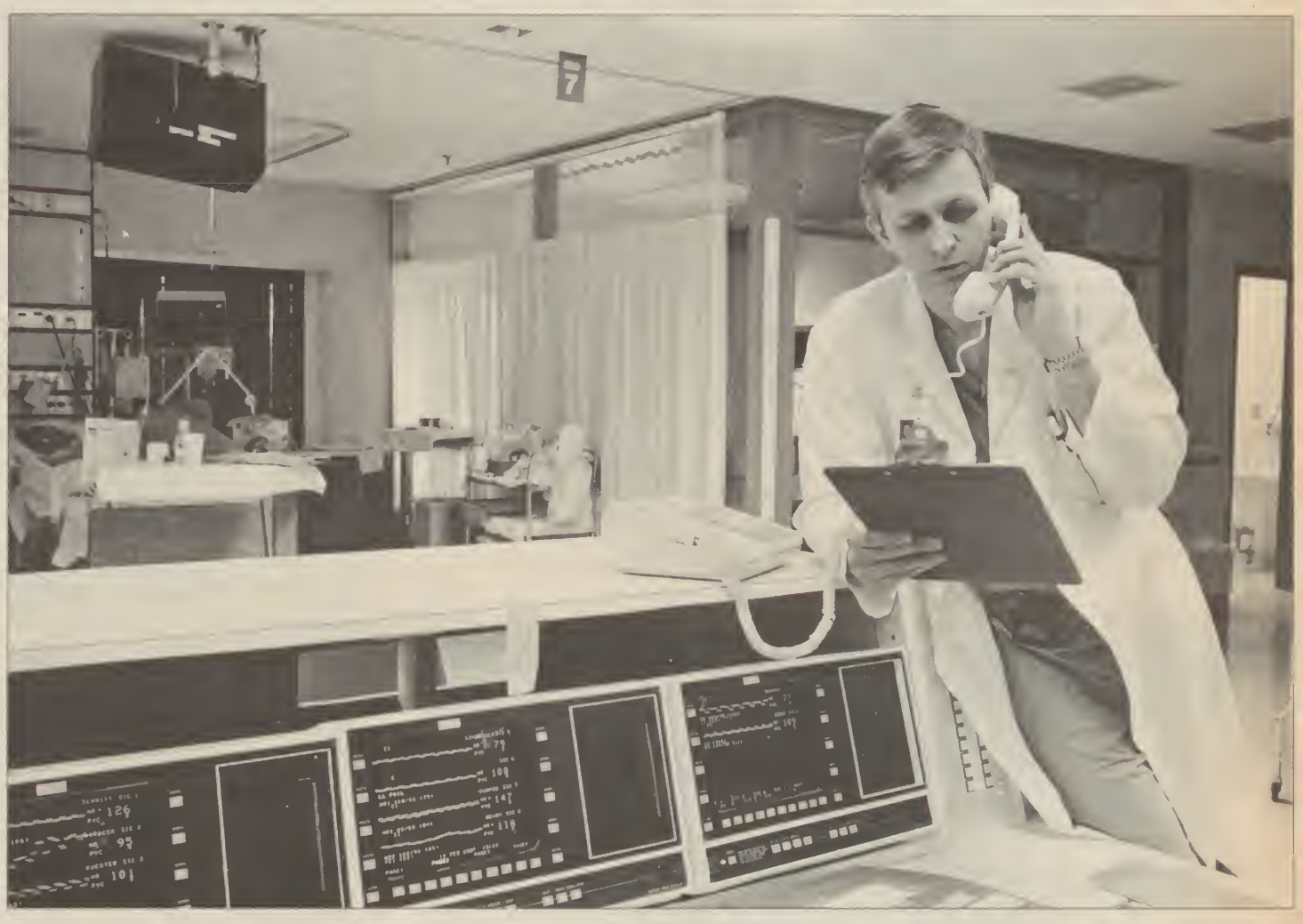
Under two other bills aimed at protecting police officers and paramedics who treat emergency victims with communicable or infectious diseases, non-written informed consent of HIV antibody testing will be allowed when a law officer is contacted by blood or bodily fluids from a possibly infected individual. The bills, signed by the governor, will be effective January 1, 1990. Last year, the legislature passed a similar bill protecting other pre-hospital providers. ▲

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(continued from page 2)

Wednesday session by State Sen. Richard Newhouse, (D-Chicago), and by overnight, behind-the-scenes maneuvering among faculty opponents.

Trustees also approved a resolution reaffirming the university's commitment to the University of Illinois Hospital (UIH) as the university's primary teaching and research hospital; pledging to seek the necessary funding to build an ambulatory care center in the west side medical center district; and pledging to launch a strategic planning process to rebuild the patient census and finances of UIH and recruit faculty to replace those who have resigned during the turmoil of the past nine months.



Wm. Daniels/The Photo Partners

An overflow crowd listens attentively to the UI Board of Trustees meeting at the university on September 13.

Four points still in contention

"I think it's unfortunate that the issue couldn't have been totally resolved by now," Dr. Nadler said after the board's decision. Attributing the board's decision to a reluctance to proceed with a master affiliation agreement absent the subordinate agreement, Dr. Nadler said, "I think the university wants to be clear that the College of Medicine agreement [and the master agreement] go together at the same time."

Since mid-August a College of Medicine committee has been drafting a subordinate agreement. Judith Cooksey, M.D., associate vice chancelor for health services and chair of the College of Medicine drafting committee, told the board that there were four points in the subordinate agreement still to be resolved.

First, there is disagreement on precisely what the term "major affiliation" means in connection with Michael Reese. Second, a dispute regarding the leadership of the College of Medicine lingers unresolved. At issue is whether an academic and clinical headship based at the university can be held by the same individual who holds a Michael Reese clinical headship. Also not yet agreed to were financial issues related to the UIH Medical Practice Plan, and priority of clerkship rotations.

It had been public knowledge for several weeks that these issues, especially the first two, were stumbling blocks. Some faculty sources complained that Michael Reese officials were causing the impasse, but Dr. Cooksey said the disagreement was confined to members of the drafting committee. In addition, Michael Reese spokesman James Cipriano said Dr. Nadler was relieved when he saw the draft. "I think that Dr. Nadler was afraid that when he got the draft the language would not be acceptable in substance. It was," said Cipriano.

However, the points in contention seemed to have played a role in Newhouse's surprise appearance at Wednesday's session. Newhouse was an outspoken opponent of the original affiliation agreement, and was instrumental in its Senate defeat last June.

Sen. Newhouse questions board

Indeed, Ikenberry's plan to have the Michael Reese master agreement approved on Thursday began to unravel when Newhouse maneuvered an impromptu question and answer session with UI board members just as Wolff adjourned Wednesday's session. Newhouse said he had questions about the nature of the affiliation agreement slated for approval, the process by which the decision had been reached, and even whether a majority of the Stukel committee favored Ikenberry's recommendation. In July, Ikenberry appointed Executive Vice Chancellor James Stukel head of the committee to chart the short-term course of the hospital.

Newhouse complained that he could not foresee an overall plan for restoring a university hospital decimated by faculty and staff resignations. Moreover, the subsequent discussion revealed the next day's vote might not receive unanimous approval. Democrat trustee Gloria Jackson Bacon, M.D., of Chicago, the only trustee to oppose the original Michael Reese affiliation since its announcement last December, echoed Newhouse's concerns.

"I thought in the hiring of our consultants we were going to talk about where do we go from here, not how do we get a better agreement with Michael Reese, but rather what in a global sense ought to be our direction as the University of Illinois Hospital," Dr. Bacon said. Dr. Bacon was referring to a report from outside consultants hired to advise the board on future courses of action (see sidebar).

Dr. Bacon did not attend Thursday's board meeting, but Newhouse said the next day the board's action should open the process for consideration of affiliations other than with Michael Reese. "I think it's appropriate," Newhouse said. "I gather from what has happened the process has been opened up; that's really what should have happened in the first place." Newhouse also would not rule out reappropriating the extra $25 million next year that the legislature granted the university to get the hospital back on its feet.

Consensus on four points near

Immediately after the board's action, talks between College of Medicine representatives and Michael Reese resumed. And as early as Friday, September 15, one day after the board's decision, significant progress on the four points in contention was being made, according to UIH medical staff president James J. Schuler, M.D.

"There are many people here who think that we are close, and the committee is coming to the conclusion that we are going to arrive at a consensus on the four points," Dr. Schuler said in a phone interview. Dr. Schuler reiterated that the consensus of the Stukel committee has been for several weeks that an affiliation with Michael Reese was in the university's best interest, but that what was needed was "a fair agreement."

Michael Reese spokesman James Cipriano concurred, saying that discussions had begun immediately after the board's action and had continued into Thursday night and all day Friday. "We're on a course of working things out," Cipriano said. ▲

UI dean steps aside as consultants rap faculty

by Kevin O'Brien

IN ACCORDANCE with a recommendation from consultants hired by the University of Illinois Board of Trustees, UI College of Medicine Dean Phillip A. Forman, M.D., said Wednesday, September 14 that he would step aside as soon as a new dean is named. Dr. Forman announced his resignation on August 8, but delayed its effective date until August 1990.

"It was my intent then that I would step down as soon as the university identified appropriate new leadership," Dr. Forman said in a prepared statement. He said that his strong loyalty to the College of Medicine had deterred him "from a more abrupt resignation." Dr. Forman also urged his colleagues "to now join together in a true, unified spirit of collegiality to adopt and pursue the long-term goals that will establish and sustain excellence in our academic mission."

Dr. Forman's statement echoed unusually strong language in the consultants' report directed to faculty opponents to the original Michael Reese affiliation plan. In addition to recommending that the affiliation with Michael Reese "be consummated as rapidly as possible," and that current Michael Reese service chiefs be retained by the university, the four person consulting team wrote that the "'scorched-earth policy' which some seem bent on pursuing could very well lead to the disappearance of the University of Illinois College of Medicine as you [and they] have known it."

"Above all," Dr. Robert G. Petersdorf, M.D., president of the Association of Medical Colleges, wrote on behalf of his colleagues, "we would like for the faculty, the staff and others to put aside their petitions, their lawyers, and their lobbyists to behave like the professionals they are supposed to be." ▲

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Poll results

(continued from page 1)

a woman the right to choose abortion for any reason during a pregnancy's first three months. But 43 percent would allow it only in cases of rape, incest or danger to the mother's life. Only ten percent oppose abortion at all times.

Teeter views the Illinois respondent's split opinion on abortion as a signal that "the media have in many ways oversimplified [public attitudes on] abortion. The great majority of people are not far-out pro-life or pro-choice," he said. "They tend to divide themselves into much finer categories. They generally think abortion should be legal, but they do want to impose some regulation and restrictions," he noted.

Biggest medical problem: health care costs

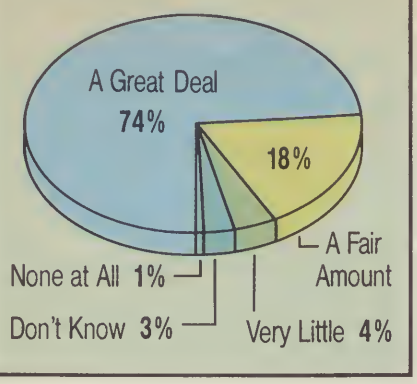
The most important problem facing health care and medicine in Illinois is the high cost of health care, according to 48 percent of Illinois voters. An additional 15 percent cited medical insurance, including its high cost, coverage inadequacies and lack of availability, as medicine's most pressing dilemma.

In comparison, diseases such as AIDS and cancer ranked low, at 11 percent and two percent respectively.

Most Important Health Care and Medical Problems

High Cost of Health Care	*48%*
Lack or Availability of Quality Care	*23%*
Care of the Elderly	*21%*
High Cost of and/or Inadequate Insurance	*15%*
Care of Others in Need	*13%*
AIDS	*11%*
Malpractice/Ethics	*5%*
Other Diseases	*4%*

Effect of Medical Malpractice on the Cost of Health Care



Illinois citizens were unwilling to spend more tax dollars on health care. When asked to choose the single most important area in which to spend additional tax money, health care ranked lowest—at only two percent—compared to education (57 percent), drug problems (10 percent), crime (six percent) and unemployment (six percent).

"Clearly, education is a government responsibility," explained Teeter. "But the public sees a much bigger piece of health care costs coming from the private sector—whether from insurance or their own pocketbooks. They don't see health care to be as much of a public responsibility as they do drugs and education."

Teeter cautioned that the public's seeming unwillingness to spend more tax dollars on health care must be placed in careful context. "The majority of people in this state are protected against health care costs, with only six percent in this study saying they don't have any insurance."

Solutions to Illinois' health care cost dilemma won't be easy, according to Teeter. "Most people and most politicians know that in order to give everyone the amount of health care they may want, the costs would be almost prohibitive. Nobody can afford that, whether it's the government or the private system paying the bill."

Child abuse: great personal concern

When asked to rate their level of personal concern toward health care problems, Illinois citizens indicated child abuse was as great a concern as drug abuse. Both issues received an 8.6 rating on a ten-point scale.

"I think it's a surprise," said Teeter that the child abuse issue ranks as high as it does. But he added it's not surprising people are growing very concerned over children. "This is perhaps a leading edge of a growing public issue," he predicted. "Less government money goes to children than it used to," Teeter noted. "I think there's an increasing concern that we have a whole series of very serious problems with children, ranging from child abuse and teenage pregnancy to drug use, quality of education and latchkey children."

Abortion

Under which of the following circumstances should a woman have a right to an abortion?

For any reason during the first three months of pregnancy	41%
Only in cases of rape, incest or danger to the mother's life	43%
Oppose abortion at all times	10%
Don't know/can't say	4%

Malpractice progress

Since 1984, the public has become more sensitive to some issues concerning malpractice. For example, currently, 74 percent of Illinois voters say medical malpractice affects the cost of health care a great deal, compared to 53 percent who thought so in a 1984 ISMS public opinion survey.

Illinois voters split nearly two-to-one in favor of placing a limit on non-economic losses, with 62 percent favoring a limit and 32 percent indicating there should be no limits on jury awards.

"The awareness of malpractice in Illinois, and its contribution to health care costs is up dramatically since 1984," stressed Teeter. "I think that alone is important. There's much more of an understanding."

According to Teeter, the comprehensive medical malpractice reforms achieved by ISMS in 1985 make progress now more difficult. "You've achieved almost everything except caps on non-economic awards. In doing so, you've relieved some of the problem and thus, some of the pressure, because awards are more stable and there are fewer suits."

ISMS remains firmly committed to capping awards through future legislation. Teeter's analysis indicates the complicated nature of achieving that goal.

Political outlook

Based on survey results, Teeter also looked ahead to the 1990 state and congressional contests, predicting that "they will not be party or single issue elections. In the governor's race [voters] are going to judge the two candidates—presumably Edgar and Hartigan—on which one has the competence and trustworthiness to make the decisions that will impact the state," he said, "especially after they've had a long term governor who has been pretty popular overall." ▲

Abortion Regulations

Do you favor or oppose:

Not allowing abortions to be performed in public hospitals unless the abortion is required to save the woman's life?

Favor		Oppose		
Strongly	Somewhat	Strongly	Somewhat	Don't Know
36%	15%	33%	11%	3%

Requiring that women under the age of 18 get parental consent before they are allowed to have an abortion?

Favor		Oppose		
Strongly	Somewhat	Strongly	Somewhat	Don't Know
53%	14%	18%	10%	4%

Using state funds to pay for abortions for women who cannot afford them?

Favor		Oppose		
Strongly	Somewhat	Strongly	Somewhat	Don't Know
27%	23%	31%	14%	4%

Medicaid

(continued from page 2)

Quality Incentive Program (QUIP) to more effectively incorporate quality of care objectives by moving a cost-to-ceiling approach for direct care costs, increasing support cost ceilings, and allowing for improvements in the capital portion of the rate.

- The development of alternatives in long-term care, the establishment of specialty Medicaid partnerships to incorporate long term and home health care, and the encouragement of home health services.
- Raising reimbursement rates, in conjunction with reimbursement system changes, for physician and long-term facilities.

The report says that most Medicaid residents live in concentrated areas of urban poverty, while physicians tend to be located near hospitals and private-pay patients, and that the access problem is particularly acute among pregnant women and children.

Moreover, low reimbursement levels are cited as the primary reason for a low rate of physician participation in the Medicaid program. According to the report, 12 percent of Illinois physicians provide 70 percent of all services provided under Medicaid.

For example, even with substantial increases in Medicaid payments that took effect September 1, reimbursement for routine office visits will be only $18 compared to $30-$40 paid by private insurers. Similarly, Medicaid rates for total obstetrical care including delivery will be an average $776 as compared to an average $1,500 from private payors. "Add to these differences the length of time and paperwork required to get payment from the Medicaid program, and it is clear that physicians have little incentive to participate," the report says.

The report contends that the low participation rate raises a quality of care concern because of the limited time allotted to each patient. Based on IDPA FY 89 data, the report says 17 percent of services were provided by doctors delivering what IDPA considers a "maximum" of 8,000 services, which worked out to 15 minutes per appointment, not including non-Medicaid patients. For an all-Medicaid caseload, more than five percent of services by physicians delivering more than 13,000 services per year translated to less than eight minutes per appointment. For a 75 percent Medicaid caseload, the appointment length was around six minutes.

The report credits the ICARE program with successfully controlling costs by forcing hospitals to compete for Medicaid patients. However, cost-controlling measures by private insurers and other private payors have fundamentally altered the financial structure of hospitals, making it more difficult for hospitals to shift costs to private payors. Consequently, the report states that a broader reimbursement system incorporating both hospital and physican care, as well as RBRVS is warranted. ▲

Assessment notices mailed: don't panic

PHYSICIANS who furnished service occupation tax information to the Illinois Department of Revenue this past summer have begun to receive penalty assessment notices—but now is *not* the time to panic.

The Department's computers automatically kick out the notices, according to a letter accompanying the notices. The letter explains the letter code appearing in the upper left-hand corner of the notice. The letter "A" means the assessment is being reviewed by the Department's Board of Appeals and requires no additional action.

However, three other letter codes indicate further action must be taken, either by the department or the physician. See the accompanying box for an explanation of the codes.

In most cases, including those returns that contain errors made in good faith, penalty assessments reviewed by the Board of Appeals will be cancelled as part of the department's medical professionals project, provided there is no additional tax due. Physicians will be notified of the Board's action.

Service occupation tax assessment codes

To determine the penalty assessment code, check the upper left-hand corner of the notice.

An "A" code means the assessment notice will be automatically reviewed by the Board of Appeals and requires no further action. In most cases, these assessments will be cancelled.

A "K" code means the Department of Revenue tried to process the return and either needs more information, or found an error indicating more tax is owed, or both. Check the assessment notice, make the necessary correction, and, if required, pay the additional tax.

A "B" code means the amount due shown on the return was not paid in full when the return was filed. In some instances, the taxpayer requested a payment plan, in which case a department representative will contact the taxpayer. Those not requesting a payment plan will be sent a bill for the balance due.

A "G" code means the return was not signed, or there was some other problem with the return. Instructions on how to follow up will appear on the notice.

Returns with errors made in good faith will be eligible for Board of Appeals review, assuming no additional tax is due. Questions regarding assessment notices should be directed to the phone number listed on the notice, or to the department's problems resolution office at 217/785-7313. ▲

At press time, only a few hundred notices had been sent, and these to taxpayers who filed several weeks before the August 15 deadline. The remaining notices will be processed during the coming weeks. ▲

HCFA deadline nears for ICD-9 coding

OCTOBER 1, 1989 marks the end of the "grace period" extension for ICD-9 diagnostic coding on Medicare Part B claims, according to the Health Care Financing Administration (HCFA). After that date, assigned claims will be denied if a diagnosis code is not provided for the physician services listed on the claim. Although the requirement to submit diagnosis codes affects services furnished April 1 and later, the grace period ending date is for claims received October 1 and afterward.

For now, Illinois' Medicare representative will continue to adjudicate unassigned claims submitted without a specific diagnosis code and educate physicians who fail to provide diagnosis codes on claims. HCFA is currently working with the Office of the Inspector General (OIG) to develop guidelines for the penalty and sanction provisions applicable to unassigned claims. ▲

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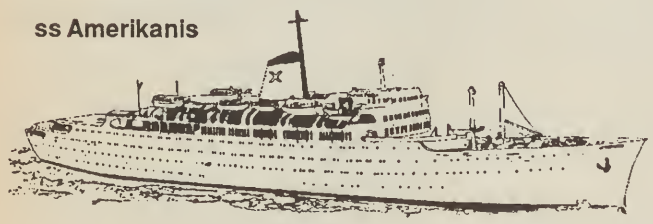
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For sale: three medical examination tables, and some OB/GYN equipment. Call 618/233-0096 on Monday, Wednesday or Friday.

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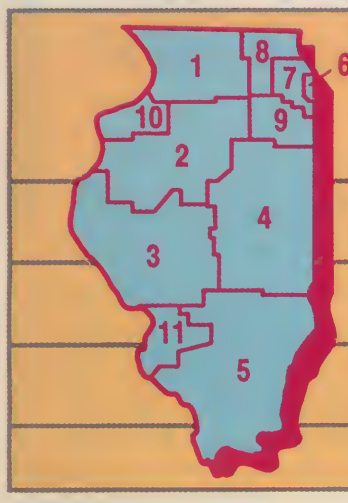
Illinois Medicine

October 13, 1989

ILLINOIS STATE MEDICAL SOCIETY

Mental illness: spot the signals . . . 10

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Average Outpatient Charges for 3 Procedures in the 11 Illinois Health Service Areas (HSAs), 1989

Procedure	Health Service Regions										
	1	2	3	4	5	6	7	8	9	10	11
CAT Scan	$378	$447	$406	$400	$391	$354	$366	$400	$460	$353	$362
Upper G.I. Series	$111	$121	$116	$120	$107	$152	$120	$131	$114	$161	$126
Bone Marrow	$554	$400	$425	$769	$629	$533	$629	$642	$406	$359	$485

Source of Data: Illinois Health Care Cost Containment Council

Report cites average costs for outpatient procedures and services

PHYSICIANS AND CONSUMERS curious about the cost of some outpatient services and procedures at Illinois hospitals can refer to a new report issued last month by the Illinois Health Care Cost Containment Council (IHCCCC). But be forewarned, the listed costs are *averages* and vary widely.

A Report of Selected Prices at Illinois Hospitals: Outpatient Services lists costs for five common outpatient services and eight outpatient procedures. The services included are mammography, computerized axial tomography of the head (CAT scan), upper GI series, HIV (HTLV-III) Antibody Detection Immunoassay (ELISA), and the HIV (Western Blot) confirmatory test.

Outpatient procedures included in the report are dilation and curettage, knee arthroscopy, cystoscopy, tonsillectomy with and without adenoidectomy, cataract removal, bone marrow biopsy and bunion excision.

"Consumers should be aware that many factors go into determining charges for various procedures," said Robert Burger, Illinois State Medical



Society (ISMS) vice president of health care finance, and a member

(continued on page 16)

Chicago study reveals less satisfaction with HMO plans

by Kevin O'Brien

CHICAGO AREA employees belonging to local HMOs are less satisfied with the care they receive than those covered by non-HMO health plans, according to a study released September 28.

The new study, *Multi-Employer Study of Health Plan Participants: Satisfaction With and Utilization of Services,* focuses on patient satisfaction with employee health plans and represents a first step in an emerging trend among companies to examine the quality of health care their employees receive. It may prove to be yet another weapon in the ongoing battle to control burgeoning health care costs.

"I think it's symbolic of employers' growing interest in the quality of care that they get under the benefit plan as well as price," said John Mortimer, president of the Midwest Business Group on Health (MBGH), which commissioned the study.

The previous focus that was sup-

(continued on page 8)

UI Board acts despite lingering faculty dissatisfaction

Reese affiliation approved

by Kevin O'Brien

IT IS FINALLY DONE. After nine months of sometimes bitter controversy, the University of Illinois Board of Trustees, at their October 5 meeting in Urbana, approved 8-1 a master affiliation agreement between the university and the Michael Reese Hospital and Medical Center. By a 7-2 vote, the trustees also approved a subordinate affiliation agreement between the university's College of Medicine and Michael Reese.

"I believe we have achieved substantial consensus, not 100 percent consensus, but substantial consensus on these agreements," University President Stanley O. Ikenberry told the trustees before the vote.

As she has since the original Michael Reese affiliation was announced last December, Democrat trustee Gloria Jackson Bacon, M.D., of Chicago voted against both agreements. Democrat trustee Kenneth Boyle of downstate Chatham voted for the master agreement, but against the subordinate agreement.

Negotiations on the subordinate agreement between members of the College of Medicine, the university hospital's executive committee, and the administration continued right up to the board vote.

In the weeks since the last board meeting on September 14, the College of Medicine executive committee had unanimously approved a subordinate agreement that was subsequently altered through negotiations between university officials and Michael Reese President Henry Nadler, M.D.

While this final draft revealed four new disputed provisions, at issue finally was a provision requiring the dean of the College of Medicine to

(continued on page 2)



Gerald S. Moss, M.D., new dean of the University of Illinois College of Medicine.

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First-year medical students find many new challenges 12

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Blood supply shortage critical again in Chicago area

by Karen Sandrick

SUPPLIES OF O negative and B positive blood in the Chicago area reached the critical stage during mid-September, causing elective and scheduled surgeries requiring transfusions of these types of blood to be postponed. Despite a phenomenal response to appeals for blood donations from local residents, Chicago's blood centers will not have sufficient supplies of blood until mid-October.

LifeSource, the major supplier of blood for Chicago area hospitals, reported that supplies of O negative and B positive blood have been at critical levels since mid-August because local blood usage is up and imports of blood from other cities are down.

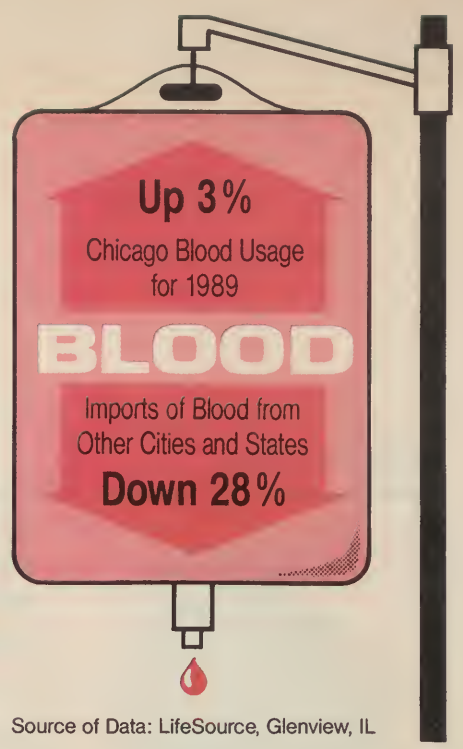
Liz Hall, marketing associate for LifeSource, explained that blood usage is up about three percent over last year for no clear reason. "There hasn't been a study of why blood usage has increased in Chicagoland," she said. "We suspect that the increase may be because patients and physicians are a little less wary of transfusion because the scare of AIDS in the blood supply has died down."

Downstate shortage also evident

At the same time, the number of units that normally come to Chicago from blood centers in other parts of the state and country has dipped 28 percent. "The other centers are going through the same kind of summer shortage that we went through: their donors are out of town on vacation, maybe their use is up, maybe they've had some major cancellations of blood drives this summer," she said.

In response to media appeals for donations, between 600 and 700 units of blood were collected on one day, "400 units more than we were expecting," Hall acknowledged.

Still, she noted, LifeSource expects blood supplies to be at the critical stage again within a matter of days. "The blood we collected will probably be used in two or three days. The crisis will not abate until mid-October when our mobile blood drive schedule will be such that we can collect the 600 units a day we need to collect." ▲



Source of Data: LifeSource, Glenview, IL

ISMS 1990 PUBLIC SERVICE AWARD NOMINATIONS OPEN

Honor a medical colleague or nonphysician for excellence in community outreach

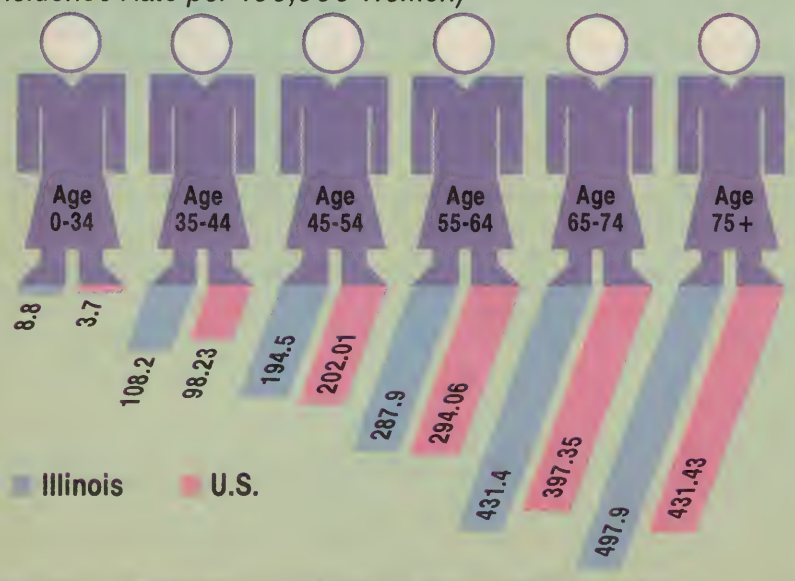
The Illinois State Medical Society is now accepting nominations for its 1990 public service awards. Granted each year to a physician and nonphysician, the award honors those who have consistently devoted time and energy to bettering the public health through medical service, education, example or community outreach.

All county medical and state specialty societies are eligible to nominate a contestant in each category: physician and nonphysician. Sources outside Illinois' medical profession can nominate non-MDs.

Nominations close November 1, 1989. Please contact ISMS public relations staff for nominating forms and criteria, by calling 1-800-782-ISMS.

Physician Facts

Age Increases Breast Cancer Risk*
(Incidence Rate per 100,000 Women)



*Source of Data: U.S. figures are based on 1985–86 averages; compiled by the National Cancer Institute. Illinois figures are based on 1985–87 averages; compiled by the Illinois Department of Public Health.

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(continued from page 1)

receive hospital medical staff executive committee concurrence when making a joint university hospital/Michael Reese service chief appointment. The failure to resolve this point led to trustee Boyle's dissenting vote.

"When you're that close to an agreement, and then it all disintegrates, it tells me that, with a little more effort on all sides, they could go back to the drawing board and they could put the thing together, and they could make an agreement work for everybody, one that everyone could live with," said Boyle.

The new agreements differ from the original affiliation agreement that was nullified last summer by the Illinois General Assembly in several respects, Ikenberry told the board.

Under the newly approved agreements, the university hospital will remain the university's primary teaching hospital. Michael Reese, together with the West Side veteran's Administration Medical Center, will be a major affiliate of the university. In the original agreement, Michael Reese had been named the university's primary teaching hospital. All department heads and clinical service chiefs will be based at the university, not Michael Reese. The term of the subordinate agreement is for 10 years, not the original 20 years. Finally, the new agreements are silent on the provision to construct a new ambulatory care center. The original agreement called for such a center to be built on the Michael Reese campus. However, Ikenberry said funds will now be sought to build such a center in the west side medical center district to replace the university's aging clinics. ▲

Trustees name new dean

by Kevin O'Brien

Gerald S. Moss, M.D. was named dean of the University of Illinois College of Medicine by university trustees at their October 5 meeting in Urbana. Dr. Moss, 54, succeeds Phillip M. Forman, M.D., who resigned in August after 12 years as dean. The trustees approved Dr. Moss' nomination by a vote of 8-0, with trustee Gloria Jackson Bacon, M.D. abstaining.

Dr. Moss, head of the college's department of surgery, is one of six Michael Reese Hospital and Medical Center clinical department heads who were appointed last April to academic/clinical headships at the university. The appointments were controversial because they bypassed traditional academic search processes, and were made according to provisions of the original Michael Reese affiliation agreement that was nullified last summer by the Illinois General Assembly.

University president Stanley O. Ikenberry recommended Dr. Moss to the trustees after receiving proposed names from executive vice chancellor James J. Stukel, who sought recommendations from the following faculty groups: the College of Medicine's executive committee and department heads; directors of the regional programs in Peoria, Rockford and Urbana; the university hospital's executive committee; and the deans of the university's five other health sciences colleges.

A Cleveland, Ohio native, Dr. Moss was named professor of medicine at the University of Chicago's Pritzker School of Medicine and chairman of the Michael Reese department of surgery in 1977. From 1970 to 1977, he was an attending surgeon and later chair of surgery at Cook County Hospital. Dr. Moss received both his B.A. and M.D. degrees from Ohio State University, and did his surgical training at Massachusetts General Hospital in Boston. ▲

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On The Legislative Scene



by Caryl Carstens

Abortion restrictions . . . Anti-abortion legislation has moved a step closer to a vote during the Illinois legislature's October veto session, with the scheduling of a conference committee hearing in Springfield Oct. 10.

At that hearing, abortion foes will try to place into H.B. 574 the same limitations the U.S. Supreme Court ruled constitutional in a decision returned July 3 on a Missouri law.

H.B. 574, passed in differing forms by the Senate and House last spring, would require physicians to test for the viability of a fetus believed to be in at least the 20th week of development prior to performing an abortion. The conference committee selected to work out the differences between the House and Senate versions didn't meet prior to adjournment of the legislature.

Missouri limitations that right-to-life supporters will present to the committee include a ban on performance of abortions in public hospitals or other tax-supported facilities unless necessary to save a woman's life; a ban on public employees, including doctors, nurses and other health care providers taking part in an abortion; and requirements similar to the bill's original content for medical testing of fetuses in at least the 20th week of development.

Except for the possible vote on abortion restrictions, legislative watchers expect the October session will generally be confined to considering Gov. James Thompson's vetoes and amendatory vetoes of bills passed by the legislature last spring.

Cocaine addiction . . . Among amendatory vetoes on which the legislature must act are several "cocaine baby" bills. S.B. 619, requiring that the Department of Alcoholism and Substance Abuse (DASA) develop a treatment program for pregnant addicts and addicted mothers and babies, was signed into law, as were bills allowing for speedy action to declare a baby born with traces of drugs in its body dependent and neglected.

However, the governor amendatorily vetoed S.B. 613, which would have required pregnant addicts to participate in the DASA program. Saying the requirement may confuse patients and waste time and resources, Thompson proposes that the bill be changed to make the program voluntary instead of mandatory. The governor's proposed amendment meets ISMS' original objections to the bill: the fear that mandating such requirements up front could dissuade addicted, expectant mothers from seeking medical care.

Thompson has also amendatorily vetoed S.B. 1413, which would require a doctor to refer pregnant women who are addicts to DASA. Thompson's proposed amendment would make it applicable only to women receiving Medicaid.

X-ray requirements . . . In other veto actions, Thompson returned an amendatory veto on H.B. 2351 which, in its original form, would have allowed physicians to certify the competence of their staff members who take x-rays, if such staffers met certain requirements for prior experience. ISMS supported the original legislation.

Thompson's amendment would change the requirements, calling for x-ray techs to have at least three years of experience prior to Jan. 1, 1980 and not less than 12 months between

(continued on page 18)

Indigent care summit set

GOVERNOR James R. Thompson, Chicago Mayor Richard M. Daley, and Cook County Board President George Dunne announced October 7 the appointment of two committees to help map out a new taxpayer-funded health care delivery system for Cook County.

"To ensure that we find the best solutions to the problems of providing good-quality, affordable health care . . . to the people of Chicago and Cook County, we have enlisted the help of medical experts and community and civic leaders," Thompson said.

Representing the Illinois State Medical Society (ISMS) on summit committees are Harold L. Jensen, M.D., ISMS Chairman, and Alexander R. Lerner, ISMS executive vice president. Dr. Jensen will serve on the policy steering committee, and Mr. Lerner on the system design and management committee. The 33-member policy steering committee, chaired by Illinois Department of Public Health director Bernard Turnock, M.D., will establish principles to be used in planning improvements to the Cook county health care system, and hold public hearings to identify its problems. The nine-member system design and management committee, chaired by Richard M. Krieg, Ph.D., Acting Chicago Department of Health Commissioner, will design changes in the county's health care system and develop steps for their implementation.

The committees were asked to complete their work by April 15, 1990. To date, no meetings have been scheduled. ▲

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(This report is a service to the physicians of Illinois)
10/13/89

Editorials

Mental illness and the medical patient

It's easy to miss the warning signs of mental illness in medical patients. Yet with 15 percent of the American population subject to some form of mental disorder, the problem is far from remote.

With the declaration of the first week in October as Mental Illness Awareness Week in the United States, Illinois and Chicago focused attention among all groups on this vexing problem. The message for medical professionals is clear. Many of those affected by mental illness (which often exists alongside or causes physical symptoms) will enter the health care system not through a psychiatrist, psychologist or social worker, but through a primary care physician treating them for another medical condition. Physicians must be alert to the broad range of mental disturbances which affect Americans and which, without the attentiveness of all medical professionals—no matter what specialty they practice—might otherwise go completely undiagnosed and untreated.

HMOs and business meet reality

Some predictable grumbling has surfaced lately over health maintenance organizations (HMOs). On one side, businesses are dissatisfied with the costs of HMOs covering many of their employees; on the other, employees are in the large majority dissatisfied with the service and access to care. These trends are made clear by the Ameritech/Midwest Business Council survey of eight Chicago-area corporations released in late September. The report comes at a time when calls for national health insurance, even from business leaders, have been mounting.

Clearly, HMOs are not the "magic bullet" some envisioned would lead to a paradise of lower health care costs through preventive medicine and wide access. Some of the cost and access problems HMOs were supposed to cure when instituted in the 1970s still remain. In fact, by promising full-service health care for a pre-set, capitated fee, HMOs may be even more vulnerable to the cost pressures buffeting medical practice today, while they try nonetheless to keep up with patients' seemingly insatiable demand for health care.

Perhaps the lesson learned here is that no system, in and of itself, offers a panacea for health care cost control, access or patient satisfaction. Every day, medicine and technology are doing more to keep patients alive and healthy. All it takes is money—to provide the research, technology and level of care that make our medical system the envy of every other worldwide. HMOs and all other health care financing systems are captive to these influences.

The changing financial equations posed by the spread of HMOs and other alternative delivery systems have led to changing relationships among all those involved in health care—physicians, hospitals, insurers, employers, and patients. All must be willing to work together to manage health care costs effectively. As the HMO study shows, solutions aren't easily found or permanent. Health care cost increases won't vanish overnight—or even in a decade. But in our collective effort to limit them, let's make sure that we do not further limit access to high-quality care. ▲

Illinois Medicine

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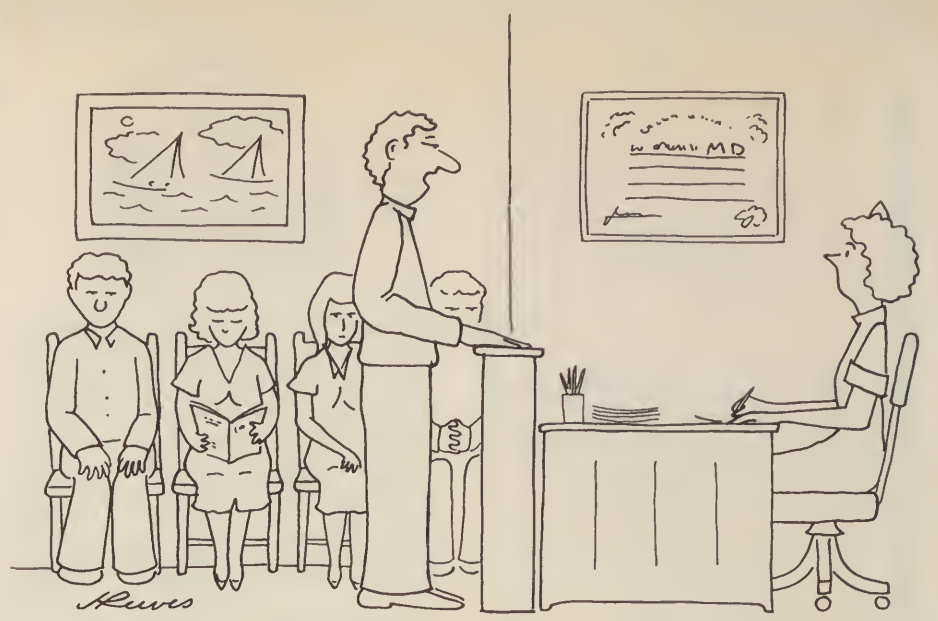
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"Having a Type A personality, I think it would be less stressful if the doctor saw me ahead of everyone else."

President's Column

A healthy development



Eugene P. Johnson, M.D.

An infant dying from measles . . . a child being turned away from school for not being immunized . . . a pregnant teen whose own health—and that of her baby—are jeopardized through lack of prenatal care.

We see these stories, and hundreds like them, in the Illinois media. From them, it's clear that many indigent citizens confront stiff barriers, both financial and cultural, to getting medical care. These barriers often lead to tragic results and health care dollars wasted in high-risk care.

Many of you who have over the years cared for Medicaid patients—or for those without any insurance at all—deserve special credit and recognition for donating your skills, despite mounting cost pressures and bureaucracy. Without your generosity, we'd face a much bigger problem.

For those of you who haven't, it's time to reconsider. There are still many without access to care. But circumstances and reimbursement levels have improved, easing the financial burden of treating Medicaid patients and still making ends meet.

Significant public aid increases have taken effect for medical services provided on or after September 1, 1989. Office visit rates have grown by over 42 percent. Obstetrical care reimbursements have been raised significantly statewide. Surgi-pak reimbursements for selected office-based surgical procedures have gone up 20 percent. And all services not otherwise covered by a specific increase have risen 16.5 percent.

One program that warrants special mention is "healthy kids." While Medicaid generally reimburses only for treatment of medical conditions, "healthy kids" allows for preventive care of well children. Known formerly as "medichek," the program has changed to encourage physicians to see patients and bill the specially-designed Medicaid rates.

Public aid's "healthy kids" program has received a sizeable reimbursement boost—to $32 for an initial screening. The number of periodic health exams covered has grown to 18 from 13 for children from birth to age 20. Reimbursement for one related followup visit has risen to $30 from just $12.65.

"Healthy kids" covers mandatory school, camp and athletic physicals annually, as well as any necessary diagnostic and lab services. The specialized, complex claim form has been discarded, allowing doctors to use standard Medicaid forms for submitting "healthy kids" bills. Immunizations are also covered.

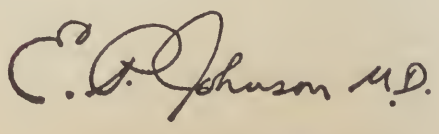
According to Department of Public Aid Director Susan Suter, "Of all Medicaid-related programs, 'healthy kids' has the greatest potential for success." She adds that, "For 'healthy kids' to really work, it needs the continued support of the Illinois medical community."

I heartily agree.

You and I know Illinois' Medicaid program is still far from perfect. Dollars are still scarce, and the bureaucracy is often enraging. But Medicaid's new increases offer a glimmer of hope.

I'm encouraged by the progress in funding and administration made this year. I think it's time for doctors who don't treat Medicaid patients to take a second look. Those who do might perhaps find time to fit one or two more into their already-busy schedules.

Giving something back is always important. The climate to do so now is better than ever. ▲



Eugene P. Johnson, M.D.
President

Letters to the Editor

"Dear Doctor" Responses

I recently read with much sadness and consternation the editorial (July 21 in *Illinois Medicine*) by Mr. Gerald Prete. His letter was filled with much cynicism and distortion. It especially saddened me to have him make the analogy that a "war" exists between the elderly and the medical profession. His resentment toward physicians making a comfortable living is tragic and unfortunate. I wonder if he has the same resentment towards peers of his own age who make a similar living. These are the same people he advocates should be allowed to have mandatory assignment and not be allowed to pay outstanding balances toward their medical bills.

I can assure you that physicians such as myself treat each individual on a case by case basis. I know of no physician who has refused to treat a patient because he could not pay his bill. I can assure you that in the middle of the night when I get called for a severe nose bleed, I do not ask the age or the insurance of the patient. Physicians like myself respond at all hours of the day on a timely basis, no matter what the age of the patient or his insurance status.

I wonder if Mr. Prete ever appreciated the fact that some of the elderly in this country could much better afford the medical bills than some of our patients in their early 30s and 40s, who have growing children and mortgages to pay. Is it fair for these people to maintain payment plans and even take out loans to reimburse the physician while members of the Medicare age population be allowed to have all their balances forgiven?

I myself have numerous patients in my practice qualifying for Medicare who have considerable wealth, and in fact, are still working. They can readily pay the doctor bills. Mr. Prete advocates that these people should not be allowed by law to pay their bills. Do similar laws exist where the same people do not have to pay the car dealer, the appliance dealer, etc.?

Yes, Mr. Prete, we can work together. However, you must face reality and review your attitude toward today's physicians. Many of us still make house calls and many of us still forgive outstanding balances without the legislation that you so strongly advocate.

Stuart A. Morgenstein, M.D.
Bloomingdale

Mr. Gerald Prete in his Guest Editorial (*Illinois Medicine*, July 21) begs the very question he raises in his title "Dear Doctor—Why Can't We Work Together."

He refers to legal and aboveboard Medicare balance billing with the inflammatory and pejorative term "excess billing." Even though the government has told us, through the "maximum allowable actual charge" (MAAC), precisely what our fees should be and notifies all Medicare recipients that they are responsible for the difference between the MAAC and what Medicare actually pays, Mr. Prete has accused doctors of charging too much!

Mr. Prete denigrates organized medicine's "clever lobbyists" and goes so far as to hint at "blackmail." What does Mr. Prete think of his own army of lobbyists, the largest of any group in the nation?

He complains about increases in charges to seniors. The only increases in charges have been those dictated by Medicare, and those have been in the 2-3 percent per year range. In fact, the discrepancy between private and Medicare charges has risen sharply as Medicare MAACs fail to reflect the realities of modern practice economics.

He says Congress is moving rapidly to address the Physician Payment Review Commission's recommendations. There is no evidence from any quarter that Congress will do anything to increase the fees that Mr. Prete says are already excessive, and in fact there is belief that AARP and other such groups will lobby against increases in Medicare fees for doctors.

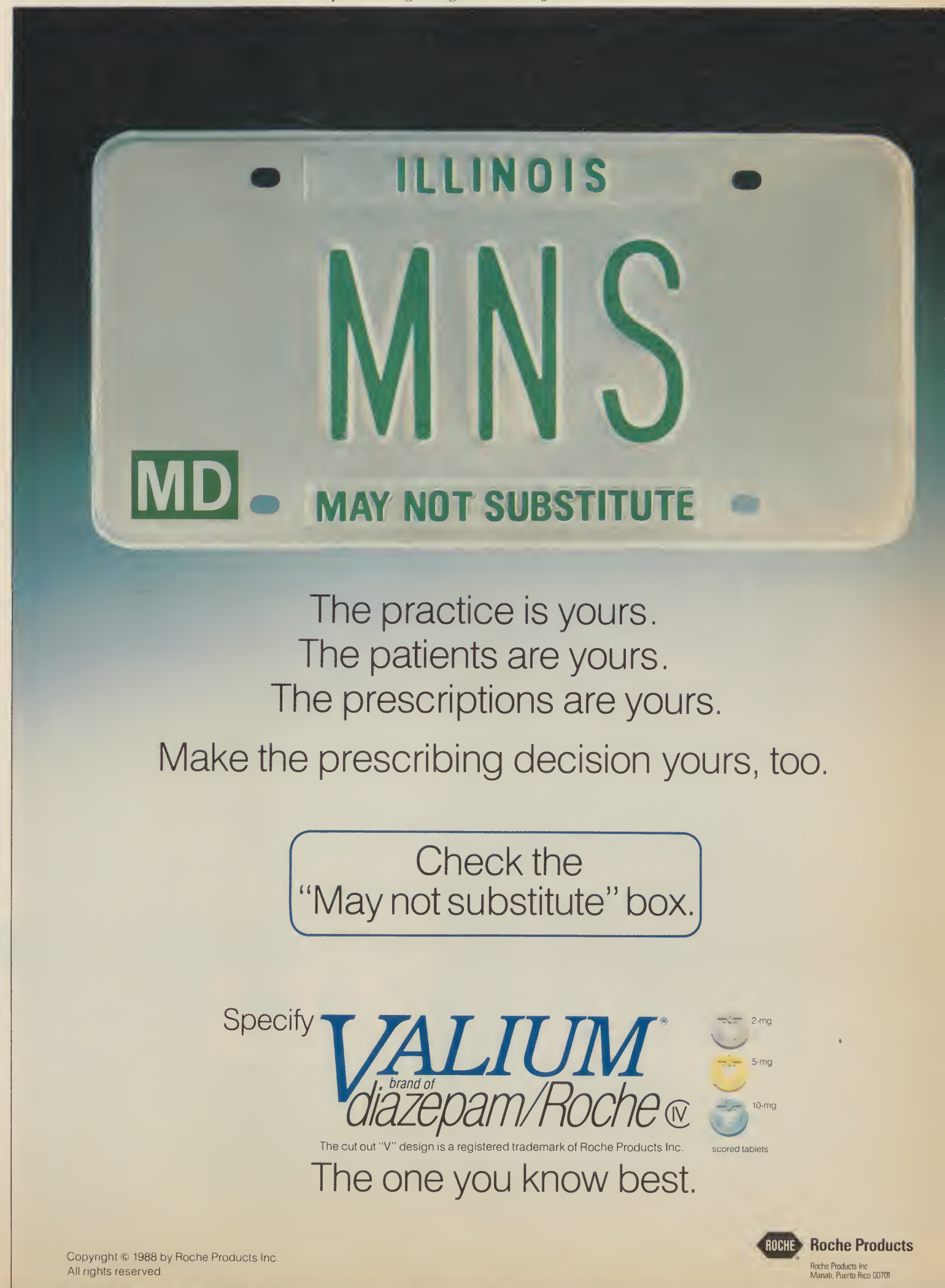
As a private practitioner with all types of patients, I resent his attempt to trivialize the efforts we have made to preserve our legal rights. Doctors do not prefer to use lobbyists, but special interest groups like Mr. Prete's have brought this issue to the Statehouse, and there we must fight.

As far as controlling the political agenda, as Mr. Prete says we do, the money that organized medicine has spent on legal, legislative and judicial issues forced upon us by repressive legislation such as the type Mr. Prete seeks has cost millions in increased fees and dues for doctors. That money might have gone a long way toward letting us work together.

Mr. Prete and those he represents are entitled to their point of view. But they must realize that political activism by doctors, although a relatively new phenomenon, must increase if we are to protect our practices from those who would impose oppressive legislation.

The agenda Mr. Prete proposes precludes working together because his idea of working together would mean surrender. No thanks.

Sam J. Sugar, M.D.
Evanston



Case in Point

A regular feature using hypothetical case histories to illustrate loss prevention maxims.

by Carol Brierly Golin
President, Medit Associates

If these were your patients, how would you have handled these cases?

Case #1

Presenting complaint—A 25-year-old mother of three who did not want more children asked her obstetrician/gynecologist to perform a sterilization procedure. In consultation with her physician, she decided upon a tubal ligation and the procedure was performed on an outpatient basis.

The case in brief—A tubal laparoscopy was scheduled and performed. The physician noted nothing out of the ordinary during the laparoscopic procedure, but the patient experienced pain and other difficulties immediately afterward and was admitted as an in-patient for observation. Four days later, a general surgeon performed an exploratory laparotomy and found a small laceration in the ileum which was leaking bowel contents into the abdomen. The general surgeon resected the injured area of the bowel and the patient's recovery was uneventful.

The resulting claim—The patient and her husband sued for negligent performance of the sterilization procedure which resulted in injury to the bowel and for delay in detecting and repairing the bowel perforation. The couple also alleged that the physician had failed to inform them that such complications could occur in connection with the procedure.

The outcome of the claim—The couple sought $85,000 in damages, including medical costs, lost wages and pain and suffering. The case was settled for $45,000.

Why problems arose with this case—The plaintiffs alleged that the injured bowel was a result of negligence on the part of the physician, while attempting to perform the laparoscopy. The four-day delay in detecting the bowel injury and repairing it weighed heavily against the physician. He also had no documentation to support that he had explained to the patient prior to the procedure that a bowel or bladder injury is a possibility when any laparoscopic procedure is done.

Case #2

Presenting complaint—A 32-year-old woman wanted to be sterilized and her obstetrician/gynecologist suggested that a bipolar tubal ligation be performed. The procedure was performed on an outpatient basis in a hospital. However, an injury to the bowel occurred in the process.

The case in brief—According to the physician, he was performing the procedure when a spark from the cautery equipment burned a portion of the bowel. He immediately called in a general surgeon who was in the hospital and responded to the OR to resect the injured portion of the bowel. The patient recovered uneventfully, but a stay of several days in the hospital was required.

The resulting claim—The patient sued for negligence in performing the bipolar tubal ligation and for failure to inform her of the likelihood of such an adverse complication.

The outcome of the claim—A jury ruled in favor of the defendant physician.

Why this case was won—Although the injury to the bowel did occur, the physician and his attorneys were able to establish that this was a possible complication of any sterilization procedure using cautery. The immediate recognition of the injury and the physician's quick action in bringing in a surgeon to repair it stood him in good stead. The physician also produced the patient's signed consent form and a copy of an ACOG brochure explaining in detail the procedure and possible complications, including bowel and/or bladder injury, which he had personally discussed with her and handed her at the time she gave her consent to the procedure.

Case #3

Presenting complaint—A 27-year-old woman who had previously given birth to three children came to an obstetrician/gynecologist for a tubal ligation. The procedure was performed and recovery was uneventful. However, the woman later became pregnant and delivered a healthy child.

The resulting claim—The patient sued the physician for negligently performing a sterilization procedure that led to the birth of an additional, unwanted child. The plaintiffs obtained a pathologist's report on operative tissue supplied to the hospital laboratory where the tubal ligation was performed, and it was shown that tissue from only one Fallopian tube was present. The other tissue was clearly from a vein.

The outcome of the claim—The case was settled for $55,000.

Why problems arose with this case—The physician admitted that he had not seen the pathology report until the negligence claim was filed. The physician argued that no matter how proficiently performed a sterilization may be, it may not be 100 percent effective in preventing conception. However, his failure to obtain and review the pathologist's report, which would have immediately indicated that only one tube had been ligated, supported the negligence allegation.

The points these cases make—Over the years sterilization claims have led to many large payouts by physicians and hospitals. The Illinois State Medical Inter-Insurance Exchange's risk management subcommittee on obstetrics and gynecology has reviewed a number of these cases and offers some thoughts relevant to the cases described:

—Communication and good rapport with the patient is very impor-

(continued on next page)

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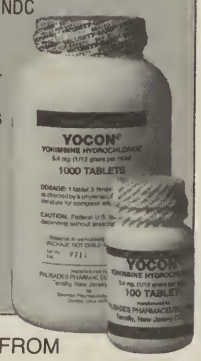
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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Case in point: a reader's perspective

The Case in Point column analyses of medical malpractice cases are usually excellent and complete. Unfortunately, the Case in Point of July 21, 1989, based on a trial, is incomplete. An important liability has been overlooked.

When the 21-year-old fell in the building being demolished and injured his dominant left arm, there was the untidy dirty laceration full of debris. In this laceration, a 3 × 1cm. piece of glass was overlooked and later removed surgically, when injuries to the median and ulnar nerves and the brachial artery were found.

A laceration full of debris, with a history suggesting the existence of a crush injury, requires under the standard of care that a complete neurological and vascular examination of the hand and forearm be performed upon arrival in the emergency room, and that a qualified specialist, hand surgeon, general surgeon—plastic surgeon, vascular surgeon or orthopedist—be called in to provide definitive care.

Under no circumstances should the exploration of such a dirty debris-containing wound be performed in an emergency room. Only in the operating room, under general or arm-block anesthesia, with good lighting and under tourniquet control, can such a wound be properly explored, contaminated dirt-containing wound edges excised, foreign bodies removed, and adjacent structures, such as nerves, arteries and muscles inspected and repaired. Thus, the duty to call in a consultant under these or similar circumstances is mandatory, as is also required by Illinois law (*Darling* v. *Charleston Community Memorial Hospital).*

The $275 verdict in this case is low compared to a $950,000 settlement in a case where a young man fell in a construction site and sustained a similar small arm laceration which was cleansed and repaired in an emergency room. X-rays were negative, but a brachial artery contusion and thrombosis were overlooked. This diagnosis was not made until several months later when a full blown Volkmann's ischemic contracture was operated on but was only partially improved.

It was the loss of function of the hand which generated this large settlement. This is why it is good ("reasonable") medical practice to obtain expert consultation whenever a fall raises the possibility of a crush injury to a limb, even in the absence of other serious injuries. ▲

T. Shelly Ashbell, M.D., J.D.
Chicago

Case in Point

(continued from page 6)

tant when an elective procedure as irrevocable as sterilization is being considered. The physician should explain and make sure that the patient understands these points, set forth by the American College of Obstetricians and Gynecologists: (1) that the procedure is *intended* to be permanent, (2) that its effectiveness *cannot* be guaranteed, and (3) that restoration of fertility by a subsequent operation is uncertain.

—Possible complications of various procedures that can be performed to prevent conception should be fully explained to a woman considering elective sterilization.

—A signed consent form should be obtained from the patient prior to the procedure and filed with the chart. If there are any langauge problems which might make communication difficult or affect the patient's understanding of the procedure and its consequences, then efforts to overcome these problems should be made. The use of an interpreter and consent forms printed in the patient's language may be necessary in some cases. If the patient is adequately informed, she will be less likely to assume that the physician did something wrong if a complication occurs.

—If anything out of the ordinary occurs during the performance of the procedure, take extra steps to document it. Examples would be multiple adhesions from previous surgeries that add difficulties to the performance of the sterilization procedure, and any complications that occur. If an injury does occur, move to rectify it as rapidly as possible and explain fully to the patient what happened and what was done to correct it. In many cases, it is not the injury itself that leads to a lawsuit, but the physician's response or lack of response to the injury that is the problem.

No guarantees should be offered that conception and pregnancy will not occur. Sterilization should be viewed as another form of birth control—one that is not always 100 percent effective.

EDITOR'S NOTE: In coming months the risk management subcommittee on obstetrics and gynecology will offer other comments that may be useful to physicians who perform obstetric and gynecological procedures to prevent or minimize potential losses from professional liability claims. ▲

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HMO satisfaction

(continued from page 1)

posedly on cutting price was really a focus on cutting utilization, says Pam Mitroff of the State Chamber of Commerce. "But as soon as people started looking at price, you started hearing things like discount medicine, and so there's a concern that no one wanted to buy cheap and not get something of value."

The difficulty is how to measure quality, but MBGH's John Mortimer thinks the new study will help in this regard. Using a survey instrument developed by the Rand Corporation at the behest of the Group Health Association of America, the survey was conducted by Gerald L. Glandon, Ph.D., associate professor in the department of health systems management at Rush-Presbyterian-St. Luke's Medical Center.

Seven Chicago corporations participate

Glandon surveyed approximately 1,800 employees of Ameritech Applied Technologies, Ameritech Services, GATX, Hartmarx, Illinois Bell, Kraft, and Zenith Electronics Corporation regarding their satisfaction with their current health care plans. Chicago area HMOs participating in the survey were ANCHOR Organization for Health Maintenance, Health Chicago, HMO of Illinois, Maxicare of Illinois, Metropolitan Life, Michael Reese Health Plan, Prucare, and Share of Illinois.

The employees were surveyed by telephone and asked to rate their health care plan in nine areas: access to care, ability to choose their physician, communication with their physician, protection from medical expenses, interpersonal skills of physicians and their staffs, quality of service provided, time spent, outcomes, and overall quality.

Dr. Glandon, in a presentation of MBGH member companies, said he found that, overall, employees of the participating companies had a higher level of satisfaction with non-HMO plans than HMO plans. Moreover, when the employees were asked whether they would recommend their current health care plans to friends, 12.1 percent of those in an HMO plan said they definitely would *not* recommend the plan as opposed to 2.8 percent of those not in HMOs.

Similarly, when asked if they intended to switch from their current plan at the next opportunity, 14 percent of the HMO participants said they definitely would switch, in contrast to only 2.7 percent of non-HMO participants.

Mortimer said that although patient satisfaction is only one indicator of quality of care, the study's results should for the first time provide participating employers with the hard data needed to support the anecdotal information they have been receiving for several years. Thus, Mortimer expects that "a dialogue between the employers in the study and the HMOs in the study will be the next step." He also said he expects the participating HMOs to use the survey results to improve their services.

Zenith Electronics Corporation, one of the participants in the study, spends tens of millions of dollars on health care-related costs each year and that costs also are on the upswing, says Zenith spokesman John Taylor. Zenith had not yet seen the study results when interviewed by *Illinois Medicine*, but Taylor said the company awaited them anxiously. "The idea is that the study will help us evaluate our overall benefits programs," Taylor said.

Company costs continue to rise

The report comes at a time when Illinois corporations, like those in other states, are watching their health care costs continue to rise, while they try to forestall government-mandated health benefits. In response, some companies in recent months have been trying to shift costs to unionized employees, and are also exploring ways to limit retiree benefits.

Although the state chamber's Mitroff says the annual rate of increase in corporate health care costs may be leveling off, it is still high. "We're still looking at increases in the 20 percent to 30 percent range on average," said Mitroff. "The predictions for 1990 are that they will hopefully remain stable, and maybe even decrease somewhat, but we're still going to be looking at increases in the 20 percent area."

"Small firms are particularly sensitive to changes in their labor costs," John Davis, state director of the National Federation of Independent Business, told legislators in January. "Mandated benefits of any kind severely restrict the ability of small businesses to continue to create jobs."

Maintaining already won health benefits was also a major factor in the recent strikes by the telephone companies, including Illinois Bell. Most were resolved when the companies agreed to establish preferred provider networks rather than shift costs to employees. ▲

HMO vs. Non-HMO

Would you recommend your current plan?

	HMO	Non-HMO
Definitely	43.7%	49.1%
Probably	34.2%	42.7%
Probably not	10.0%	5.4%
Definitely not	12.1%	2.8%

Do you intend to switch from your current plan at the next opportunity?

	HMO	Non-HMO
Definitely	14.0%	2.7%
Probably	16.6%	7.8%
Probably not	29.9%	32.9%
Definitely not	39.5%	56.7%

Source of Data: Midwest Business Group on Health, September 1989.

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VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Heart failure patients given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in heart failure patients), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (> 5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. Although a causal relationship has not been established, it is recommended that caution be exercised when lithium is used concomitantly with VASOTEC and serum lithium levels should be monitored frequently.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest; pulmonary embolism and infarction; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis.

Nervous/Psychiatric: Depression, contusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, asthma, upper respiratory infection.

Skin: Herpes zoster, pruritus, alopecia, flushing, photosensitivity.

Other: Vasculitis, muscle cramps, hyperhidrosis, impotence, blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include fever, myalgia, and arthralgia; an elevated erythrocyte sedimentation rate may be present. Rash or other dermatologic manifestations may occur. These symptoms have disappeared after discontinuation of therapy.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g % and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance >30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤30 mL/min (serum creatinine ≥3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Heart Failure Patients with Renal Impairment or Hyponatremia: In heart failure patients with hyponatremia (serum sodium <130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J6VS18R2(817)

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Board Briefs

The Illinois State Medical Society's Board of Trustees convened September 16, 1989 in Chicago to hear council and committee reports and debate a broad range of medical issues involving Illinois MDs. The highlights are:

Chairman and executive committee reports

Warren H. Staley, M.D., a Chicago obstetrician and gynecologist, was selected by the board to fill a vacancy as a third district (Chicago) trustee.

John J. (Jack) Ring, M.D., a Mundelein family physician, and current chairman of the American Medical Association (AMA), was endorsed unanimously as a candidate for AMA president-elect.

Helmet guidelines

Because removal of helmets by prehospital providers could worsen a sports injury, the council on medical services developed, and the board approved, guidelines for helmet fitting and removal in athletics, for distribution to Illinois athletic trainers, high school coaches and project medical directors. If there is any indication of a cervical spine injury, a helmet should not be removed on the field, but by hospital emergency room personnel.

Student loans

The U.S. Congress is considering legislation to restore student loan interest tax deductibility. The AMA and ISMS Resident Physicians Sections (RPS) and Medical Student Sections (MSS) are lobbying House Ways and Means Committee members on this issue (see related story on page 13). The board approved $108,000 for loans to Illinois medical students in the 1989-90 school year, and agreed that anyone receiving ISMS loans be required to join ISMS.

Senior citizen outreach program

Patient information, radio and television public service announcements and a physicians' speakers bureau to reach out to senior citizens in Illinois were approved by the board for implementation through county medical societies. Speaker's kits will be provided to physicians, along with a brochure on Medicare and other information helpful to senior citizens.

Retention of physicians' medical records

The board approved the medical-legal council's proposal for legislation for physicians to keep inactive medical records on adult patients six years and minors ten years. The proposed statute would clarify record retention for physicians, since current law does not specify how long physicians should keep patient records. ▲

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Mental illness: Primary care physicians can spot the signals

by Tina Panoplos

TAKING MORE TIME with patients is easier said than done in a busy practice, but it can play a vital role in the primary care physician's ability to diagnose mental illness, and in whether the vast majority of the mentally ill get help.

"So much of modern medicine is so programmed by the clock, by time and by money that the type of diagnostic conversation that is necessary often doesn't occur," says Katherine Zartman, a board member of the Alliance for the Mentally Ill of Greater Chicago.

The importance of such a dialogue between physicians and their patients becomes apparent when looking at the sheer numbers of mentally ill who are visiting primary care physicians.

In any given month, 15 percent of Americans experience significant mental disorder, including substance abuse, according to a National Institute of Mental Health study. Of those people, 20 percent seek help from a psychologist or psychiatrist, 20 percent receive no care at all and a full 60 percent have some type of ongoing contact with a primary care physician.

Patrick Staunton, M.D., chairman of the department of psychiatry at Lutheran General Hospital in Park Ridge, says most physicians recognize overt psychosis, schizophrenia and delusional states, but may not be as quick to recognize anxiety or phobia states, substance abuse or clinical depression.

A family history may prove helpful in diagnosing mental illnesses that have hereditary links, such as schizophrenia and manic depression, but is often difficult to get. Because of the stigma of mental illness, a relative's illness may have been concealed by family members, so a patient might not be aware of mental illness among relatives. He might, however, be able to tell a physician whether any family members have had long, unexplained absences, or whether a relative was bedridden with a "heart condition" for an extended period.

In addition to getting informed about the symptoms of mental illnesses, Dr. Staunton suggests that emphasizing the human dimension of medicine can help physicians detect mental illness in their patients. That means spending more time with patients and their families, and taking the time to get to know patients better as human beings.

Chicago psychiatrist Richard K. Baer, M.D., points out that many people who visit a general practitioner might have a psychiatric disorder that manifests itself in physical complaints. A person might complain of headaches, fatigue or loss of appetite. To determine if the complaints have been brought on by a mental illness, a physician's index of suspicion has to be very high, says Dr. Baer. The physician needs to ask about the patient's emotional well-being, ask how things are going at home. "Physicians have to be experts at listening," Dr. Baer says, acknowledging that such an approach can be somewhat time-consuming.

Thomas Tourlentes, M.D., chairman of the Illinois Psychiatric Society's (IPS) public affairs committee, says that if physicians take the time to listen, their patients will usually tell them what's wrong. Often, however, patients are intimidated by physicians. They think that their physician is too busy to hear about their problems, so they don't want to take up their time. It becomes a self-fulfilling prophecy, said Dr. Tourlentes, an associate clinical professor at the University of Illinois College of Medicine in Peoria.

Attitudes toward mental illness also might make patients reluctant to admit that something is wrong with them. "Most people seem to prefer to have a physical illness," says Dr. Baer, even though mental and emotional illnesses are safer. Compare the headache caused by emotional problems, for example, to the one caused by a brain tumor.

But physical and mental illness don't always occur independently of each other. Chronic medical disorders can co-exist with clinical depression, for example. Failing to treat the depression can often complicate a person's physical condition.

Depression can lead to suicide, affect the immune system or result in non-compliance with medical treatment, notes Nada L. Stotland, M.D., its president and an associate professor of clinical psychiatry and obstetrics and gynecology at the University of Chicago.

Dr. Stotland points out one common pitfall in recognizing depression. "If sad things have happened in a person's life, a physician might say, 'No wonder they're feeling despondent'," says Dr. Stotland. The physician might dismiss a person's need for treatment.

While depression is the most common form of mental illness, affecting one in five people at some point in their lifetimes, it also is the most treatable.

Among the recent advances Dr. Stotland notes in treating mental illness are two major drugs for depression, new psychotherapy and drugs for treatment of obsessive-compulsive disorders, and more effective diagnosis and treatment of people with brain damage and tumors. "All psychiatric disorders are treatable," Dr. Stotland emphasizes. She encourages physicians to refer those they suspect have a mental illness to a psychiatrist, who she said are in the best position to determine treatment, or make a referral if they feel psychiatric treatment isn't necessary.

Such referrals aren't always affordable, though. "Most medical insurance severely discriminates against mental illness," Dr. Stotland says.

Indeed, a study conducted by the League of Women Voters of Illinois' education fund confirms that assertion.

Of the 202 families of the mentally ill interviewed for the League's study, nearly 90 percent reported that their relatives were hospitalized in private hospitals at some point, but 60 percent eventually turned to state hospitals because of limited family funds and inadequate insurance coverage, according to the 1989 report *A Profile of Community Services for the Mentally Ill in Illinois.*

Insurance coverage aside, physicians may be reluctant to approach patients about the need for psychiatric treatment. "In practice, many physicians assume the patient will be offended . . . and that in fact happens sometimes," says Dr. Baer. He adds that the success of a referral depends on the patient's trust of the physician. If a physician a patient has been seeing for years suggests psychiatric treatment, the patient may not like it, but he'll often follow the physician's advice.

Physicians who have a good working relationship with a psychiatrist can make a referral less threatening by how they word the suggestion.

Dr. Tourlentes suggests telling the patient something to the effect that, "Dr. Jim is a great friend of mine. I

(continued on next page)

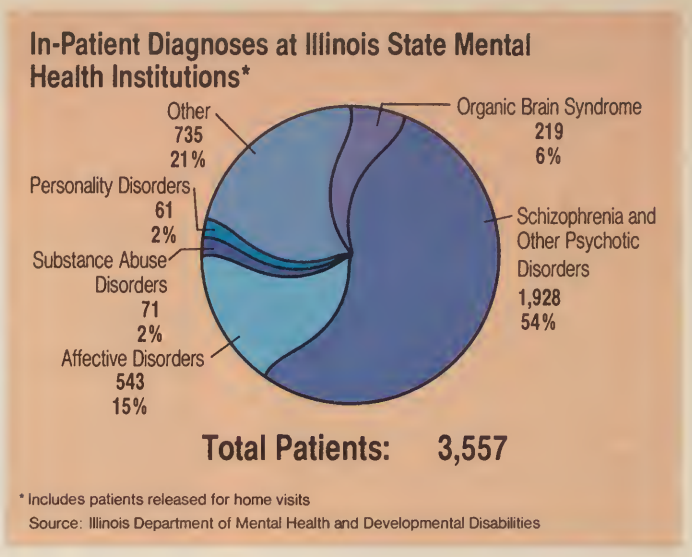
Signs of depression

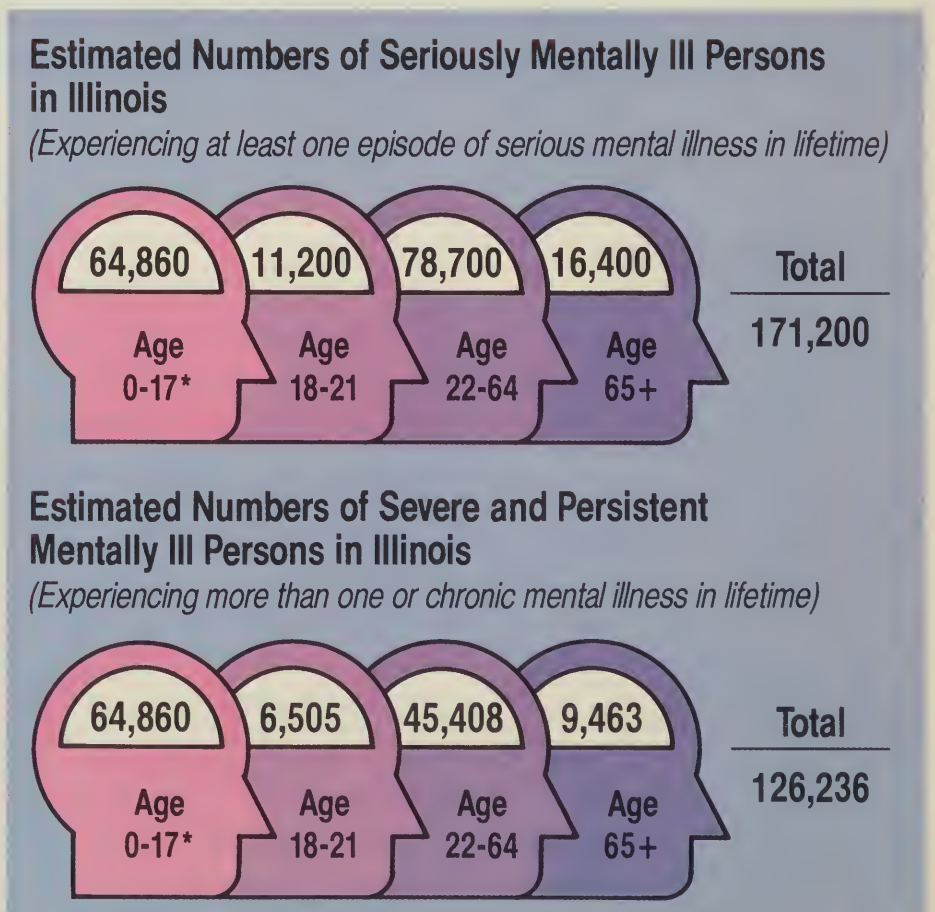
Depression is the most common form of mental illness, affecting 9.4 million Americans in any six-month period. Feelings of sadness, helplessness, hopelessness and irritability, when accompanied by any four of the following symptoms, could signal that someone is suffering from depression:

- Change of appetite.
- Change in sleeping patterns.
- Loss of interest in activities formerly enjoyed.
- Fatigue.
- Feelings of worthlessness.
- Inappropriate feelings of guilt.
- Inability to concentrate or indecisiveness.
- Recurring thoughts of death or suicide, wishing to die, attempting suicide.
- Overwhelming feelings of sadness or grief accompanied by waking at least two hours earlier than usual in the morning, feeling more depressed in the morning and having significantly slower motor skills.

A few severely depressed persons may develop disturbed thinking. ▲

Source: American Psychiatric Association.





Families struggle with mental illness, too

Coping with mental disorders is as much an ordeal for the families of the mentally ill as it is for patients themselves.

First, there is the trauma of discovery of the family member's illness. The discovery of mental illness in a family can be shattering. "The malfunction of the brain is the most devastating of all diseases," says Katherine Zartman of the Alliance for the Mentally Ill of Greater Chicago.

Next comes the trauma of having to deal with the social implications of the illness. The stigma against mental illness is so great, Zartman notes, that when people think they or a family member may have a mental illness they're often unable to tell anyone about it. "Mental illness combined with secrecy and fear of stigma becomes almost intolerable," she says.

Families often feel shut out by the health care system as well.

A recent study by the League of Women Voters of Illinois' education fund found that 49 percent of 202 families interviewed felt they had received inadequate information about a mentally ill relative's diagnosis and treatment recommendations.

"A large percentage of families are left in the dark regarding the full extent of their relatives' illness and prognosis," the group reported in its study, *A Profile of Community Services for the Mentally Ill in Illinois.*

Confidentiality laws that protect the rights of patients can sometimes leave family members groping for answers.

"You can't betray the confidence of people," says Thomas Tourlentes, M.D., chairman of the Illinois Psychiatric Society public affairs committee. "If a patient wants to keep his health care a personal matter, physicians can't ignore that," Dr. Tourlentes says, though he suggests that physicians can talk to patients about keeping family members informed about their illness.

Even if the family is involved in their mentally ill relative's care, the family's needs in dealing with the illness are often unmet.

Because of this, some people find help through groups such as the Alliance for the Mentally Ill, a national organization with some 900 affiliates that offers support to the family members of the mentally ill. In Illinois, individuals can call (800) 346-4572 for information.

Zartman sought out the organization three and a half years ago for help in dealing with her mentally ill son. The son, who suffered from severe schizophrenia, received care at a private hospital for four years before committing suicide just three weeks before he was to be released.

Before his death, his condition had improved greatly with the use of an experimental drug, but he was suffering increased panic attacks, perhaps as a result of the drug or perhaps because he was going to be released soon.

If Zartman had known to get help sooner or had been aware of the danger of rapid recovery the outcome might have been different, but she feels confident that her son received very good care.

"We did the best we knew how to do at the time," she said.

What Zartman felt was lacking, though, was help in coping with the mental illness. "By the time I learned about the Alliance for the Mentally Ill," she said, "my son had been sick for two years." She learned about the group through a book she had bought written by a woman whose son had schizophrenia.

"I never heard about it from any doctors or social workers," she said. And she wasn't aware of the organization at the time she now says she needed it the most. ▲

Spot the signals

(continued from page 10)

have a lot of confidence in him. I'd like you to meet with him to talk about the things we've discussed here."

"Don't put it in terms of 'You're crazy'," Dr. Tourlentes said, "because most people aren't."

Dr. Stotland believes it's best to make a psychiatric referral early on. Waiting until all the tests come up negative and then telling a patient their symptoms are "all in their head" can put a patient off.

One approach Dr. Stotland suggests is to tell a patient that not knowing what's wrong with him is very stressful and maybe a psychiatrist could help him deal with that stress.

Physicians should work as a team with the psychiatrist and stress an ongoing interest in the patient, she added. They shouldn't refer a patient to get rid of him. Making additional appointments with the patient is important, as is following up to find out if the patient is happy with the referral or would prefer to see a different psychiatrist.

And physicians should remember that the physical complaints of the mentally ill patient are real.

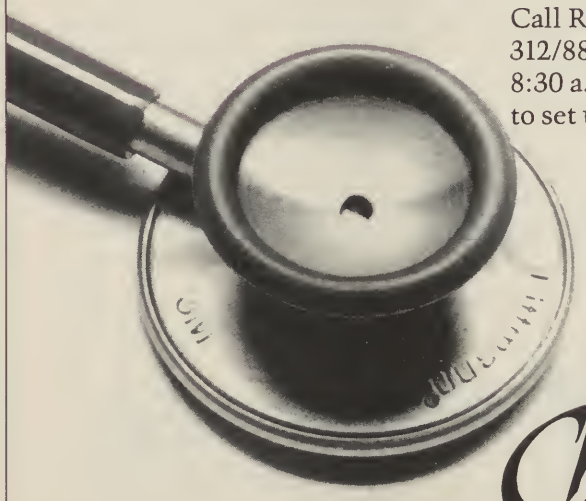
As Dr. Stotland puts it, "Don't ever tell a patient that they don't have their symptoms . . . The person *does* have pain." ▲

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Medical students find challenges and changes as freshmen

by Janice Rosenberg

EVERY YEAR, nearly 17,000 new students enter U.S. medical schools as freshmen. Their experiences differ both from those of physicians now in practice, many of whom went through med school at a time when nearly all doctors were assured of a relatively comfortable, debt-free post-residency lifestyle, and from those of their immediate predecessors, who entered school in the late 1970s and early 1980s, when competition to get in was fierce and battles raged over who would be allowed into one of the most exclusive professional school groups around.

Today, qualified students are having little trouble getting into medical school. In the late 1970s, there were three applicants for each spot; last year, according to Daniel Burr, M.D., associate dean for admissions at Loyola Medical School, there were fewer than two. "We're not turning away qualified people," says Dr. Burr. "Unless you do something very foolish in your application process, you're most likely to be admitted."



Wm. Daniels/The Photo Partners

Michael Beyer: "Medical school is an incredible commitment."

"It would be fair to say that anybody with a B average who averages eight or nine out of fifteen on the MCATs (Medical College Admissions Tests) will get into medical school," agrees Roger Robinson, assistant dean of students at Southern Illinois University Medical School in Carbondale.

One reason the admissions situation has changed is because of growing awareness of the physician glut in large metropolitan areas—those most likely to offer high-paying practice opportunities—and because of the growing burden of debt most medical students are taking on in order to finance their training. Tuition at Loyola University's Stritch College of Medicine, for example, is $13,800 per year for Illinois residents, while those from out of state pay $16,750.

In contrast, tuition at some state-supported medical schools can be much cheaper. At Southern Illinois University Medical School, students pay only $2650 per semester for nine semesters, while the final year of their schooling is free. Out-of-state students, 10 percent of the total, pay three times as much. This year 72 students began classes at Carbondale, nearly 35 percent of them women. All will move to Springfield for the second through fourth years of study.

Making the grade, making the cut

The vast majority of students who began medical school this year will graduate. "When we admit people we're selective," says Dr. Burr. "Of this year's 130 we expect all will eventually graduate, but in a typical class from two to four will get recycled into a different class after taking leaves of absence to work in research or earn another science degree."

At SIU, Robinson reports a one percent attrition rate that matches the national average. "Minority students don't quit," he added. The typical dropout is a white middle-class male. "There's a certain phenomenon where the big apple is getting in and once they're in they're faced with the grind. The shine wears off and they say 'Hey, I don't really want to do this'."

J. Kevin Dorsey, M.D., Ph.D., head of curriculum at SIU, does not see a great deal of difference between the students he taught in 1973 and those that he is teaching now. "They still come in with high ideals and a dedication to learning how to serve humanity," says Dr. Dorsey. "Admissions were down and it was thought that all the good students were going into business or banking. I think what we're seeing are the less entrepreneurial students. The ones we have are good people. They care."

The shrinking applicant pool will not cause Loyola to lower its standards, reports Ralph P. Leischner, M.D., a 1968 Loyola medical school graduate and dean of academic and student affairs at Loyola. "We have been prepared to decrease our class size if necessary," he says.

Learning the time-tested way

According to Dr. Leischner, the greatest problem facing today's students is the rapid increase in medical knowledge. "Experts bemoan the fact that the present-day curriculum presents too much material for the students to digest," he said. Dr. Leischner believes that instead of stressing the memorization of facts, medical schools should focus on teaching problem-solving along with the ability to think critically, analyze data, and draw conclusions. "There should be a greater emphasis also on

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interpersonal skills," he adds.

He, too, senses a high level of idealism in the student population. "The students come in chomping at the bit not only to have patient contact, but to do something quantifiable as far as helping another person."

At Loyola, first- and second-year students have few such opportunities. Following the traditional medical school dichotomy between the first two years of basic sciences and the second two of clinical experience, they concentrate on lectures and laboratory work.

By contrast, SIU students are given early and frequent clinical exposure. "In their fourth week students take medical histories from real patients," says Dr. Dorsey. "We believe the basic sciences will make a lot more sense and be remembered better and longer if they're hooked onto patient experience."

As part of this philosophy, students are given the opportunity to work with physicians in the family practice center. "SIU is not known for its research," says freshman Sam Kelly of Coulterville. "So it makes sense that the emphasis is on patient care." Kelly expected medical school to be a "killer," but has not found it quite that difficult. "I majored in biology and right now medical school is a lot of reviewing."

According to Roger Robinson at SIU, there is tremendous pressure on pre-med students to be science majors. MCATs demand extensive knowledge in the sciences which nonmajors may not have.

Why they're there

Despite her love of science, Sheri Y. Springs-Phillips of Chicago, a Loyola freshman, chose to major in psychology as an undergraduate at Northwestern. "I felt that I was going to be in science the rest of my life," she said, "and I felt that knowing about people's attitudes and moods would help me in medicine. Maybe I'm spending a couple of extra hours a night studying, but my point was to do something that was interesting in college."



Wm. Daniels/The Photo Partners

Sheri Springs-Phillips: "I felt that I was going to be in science the rest of my life."

The majority of students go directly from college to medical school, but some have from one to several intervening years. Michael Beyer of Chicago, a Loyola freshman, admits the first six weeks of school were harder for him because of his three-year hiatus. But he doesn't regret taking the opportunity to work and travel. "Medical school is an incredible commitment," he said. "I knew once I got in I wouldn't have time."

At 30, Jean Cooper of Charleston, the mother of a four-year-old daughter, is one of the older SIU freshmen. She has a master's degree in history and had to go back to college for two years of science courses before applying to medical school. "For me, the time in between was helpful," she says. "I've tried other things. I have the definite feeling that this is what I want to do with my life."

Clearly, there's more than one path leading to medicine. John Hassapis of Chicago, a senior at Loyola, at one time considered a career in economics. "Once I was in college," he said, "I found it very boring. What I found exciting was chemistry and biology." Hassapis also enjoyed working with people and talking to them. He decided that medicine would be a good way to channel his interests. "I'm glad I made that decision," he said. "I'm still having fun." ▲

. . . And then comes the student loan challenge

by Janice Rosenberg

Attending medical school is an expensive proposition, which means that few students can afford to pay their tuition bills without student loans. According to Pat Collins, assistant to the dean and director of financial aid for the University of Illinois Medical School at Chicago, at least 80 percent of the school's students receive some assistance. "A federal methodology is used to determine need," says Collins. "It's the same across the country. Eighty percent of the dollars an individual student gets tend to be federal."

With the help of financial aid officers, entering medical students complete a needs analysis form to determine eligibility for the federal guaranteed student loan program. Also known as the Stafford student loan program, it is *not* limited to medical students. Robert Dame, director of financial aid at Rush Medical College, calls it "good money." Students apply for the Stafford loan first because of its reasonable interest rate.

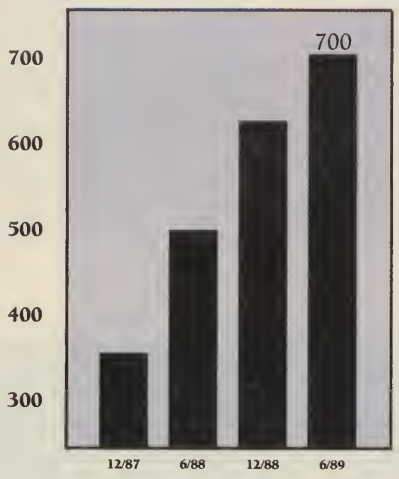
"Repayment of a federal loan is figured at eight percent interest

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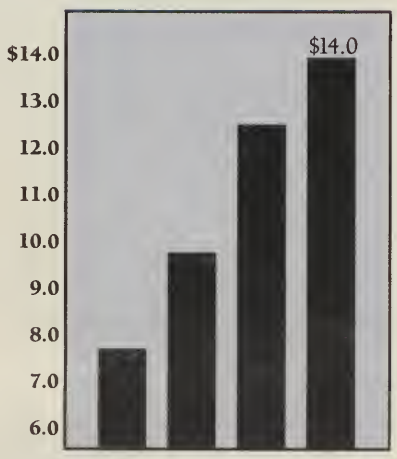


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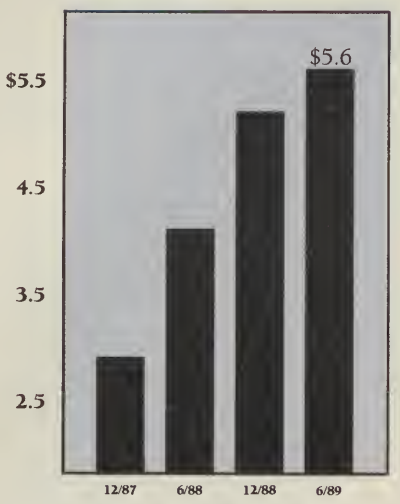
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Loan challenge

(continued from page 13)

for the first four years," explains Mary Mega, a loan officer at Loyola University Stritch School of Medicine. "Then it jumps to 10 percent." Interest does not accrue while the student is in school. The Stafford loan supplies a maximum of $7500 per year; to pick up the slack, students can also apply for a supplemental loan for students.

"Most banks participate in the Stafford program," says Collins, who advises students to try to obtain the money through their family bank: "I tell them to pick an institution they'll be happy with." Loans requiring no collateral are also available through open lenders like Citicorp Savings and Loan and the First National Bank of Chicago.

Students who borrow $5000 or less have five to six years to repay; those who borrow more have ten years. Questions have arisen recently concerning when students who have graduated from medical school should be required to begin repaying their loans. According to Collins, the Stafford loan offers a general deferment option to anyone who requires an internship prior to beginning work. "This can be in medicine, but it can also apply to dentistry, physical therapy, interior design, clinical psychology and a range of other professions," she pointed out.

A second Stafford loan deferment option called "full time study" allows teaching hospitals to define their residents as "students" throughout their residencies. Under this provision, residents at teaching hospitals are able to extend their two year post-medical school grace period over the entire residency period. Because residents at non-teaching institutions are subject to the strict two-year rule, some inequities have developed.

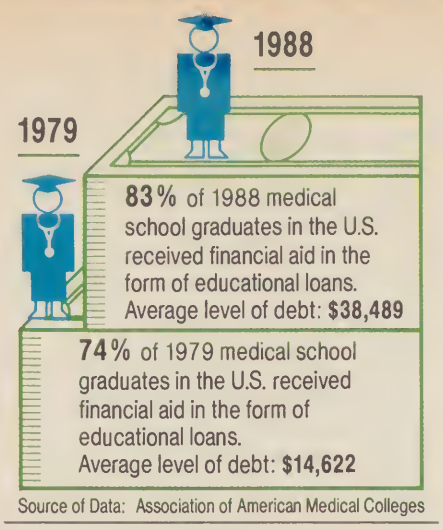
On June 23, 1989, U.S. Senator Edward Kennedy (D., Mass). introduced Senate Bill 1258 (S1258), the medical students loan amendment act of 1989. Under S1258, hospital programs would no longer be allowed to designate residents as students; instead all residents would begin loan repayment two years after medical school graduation. The bill, currently under consideration by the Congressional Budget Committee, would do away with deferment inconsistencies.

HR 747: an important loan deductibility proposal

Another piece of legislation relating to medical school loans is currently pending in the U.S. Congress. Cosponsored in the House of Representatives by Illinois 12th district Congressman Philip Crane and Richard T. Schulze of Pennsylvania, House of Representatives (HR) 747 seeks to amend the Internal Revenue Code of 1986. Prior to 1986, 100 percent of the interest on student loans could be deducted from income tax. Based on the 1986 code, this "deductibility" was gradually reduced and will cease to exist as of 1991.

The bill introduced by Congressmen Crane and Schulze would restore 100 percent deductibility. It was sent to the House Ways and Means Committee on January 31. According to Kirt Johnson, legislative director for Rep. Crane, HR 747 became a "member miscellaneous amendment" to the committee's 1989 budget reconciliation bill. Crane and Schulze anticipated that they would have time to "offer" this bill before the end of the committee's 1989 session.

"Chairman Rostenkowski laid out some guidelines under which the committee would operate in order to determine what kinds of amendments would be allowed to be offered," says Johnson. Out of 170 possible amendments, his guidelines eliminated 150, Congressman Crane's among them. "Either later this year or early next year we hope to put together a package of tax-related measures in one omnibus bill," Johnson continued. HR 747 would be included in such an all-purpose bill.



Source of Data: Association of American Medical Colleges

HR 747, if passed, would apply to all student loans. Besides the Stafford loan program, money is available to medical students through a number of other loan programs. According to Robert Dame, available money for two of them—the Perkins and Health Professions student loans—varies from school to school. "Other loans are more readily available from a variety of sources," he said.

Unfortunately for students in need, these loans carry high interest rates, often with the interest accruing to the borrower while he or she is in school. And, like all loans, they will one day have to be repaid. ▲



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Out-Patient costs

(continued from page 1)

of the IHCCCC board of directors. "The report should therefore serve as a starting point for discussions regarding outpatient costs between the patient and the physician or hospital."

First of its kind

The report lists the 235 Illinois hospitals according to federally designated health planning areas, and is the first of its kind, according to IHCCCC executive director John R. Noak. "Previous release of health care charges by the IHCCCC have related to inpatient hospital services only," Noak said. The council recently published its third annual consumer guide to inpatient services.

Each hospital provided its average price for each service or procedure as of December 1988 to the IHCCCC. These prices may include charges for basic laboratory tests and medication, routine equipment and supplies, and time spent in the operating and recovery rooms, the report says. Such charges may be excluded in some instances.

However, the prices usually do not include physicians' professional fees, nor do they include special medication, x-rays, implants, unusual supplies or extra time in the operating or recovery rooms that may be required.

Christopher Bailey, director of planning for the Illinois Hospital Association, said while price is not the determining factor in where people go to receive health care, the report is one more piece of information in a very complex decision.

"Patients bear more of the up front, out-of-pocket costs for outpatient services than they do for inpatient, so comparative price information may be [more] relevant for this type of care than for inpatient [care]," Bailey said.

Huge price range

The prices vary greatly. For example, prices for a CAT scan range from a low of $59 at Chicago's Martha Washington Hospital to a high of $687 at Mt. Sinai Hospital and Medical Center, also in Chicago. The state average for a CAT scan is $385, while the average price in the Chicago region is $354.

Similarly, a patient seeking a bone marrow biopsy at Illinois Masonic Medical Center in Chicago might only be charged $29, far below the Chicago area average of $533. However, if the patient traveled to Mattoon in east central Illinois, he could expect to pay as much as $3,804 at Sarah Bush Lincoln Health Center, considerably more than the regional average of $769. The state average is $571.

Charges vary greatly among institutions for three reasons, according to Bailey. First, the listed services are not necessarily the same set of services, but may actually be groupings of related services. For example, the cataract procedure is actually 10 different procedures that fit within that one category, some more complex than others.

"Therefore, the average charge for hospital X might be significantly more expensive than the average charge for hospital Y, because hospital X does more of the complex variety of cataract procedure," Bailey said.

Charges also may vary because some hospitals in poor neighborhoods may charge private payors more for their services than they do public aid patients. Finally, Bailey said that hospital billing procedures also vary among institutions. Some hospitals have "all-inclusive" fee information readily available, but others could not provide a component of the overall price, such as the operating charge for the bone marrow biopsy procedure.

So although the report is not always "comparing apples to apples," Bailey said it represents good news for the consumer. None of these procedures were done routinely on an outpatient basis two to three years ago. Now it is possible to avoid more expensive and burdensome hospital stays.

"Just the fact that these procedures are performed on an outpatient basis, and are therefore a much more viable alternative, is very good news from the patient's perspective," Bailey said.

Physicians and consumers can obtain free copies of the report by telephoning the IHCCCC toll-free hotline, 1-800-325-9564. ▲

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News Capsules

New AIDS research

The National Institute of Allergy and Infectious Diseases (NIAID) recently announced the establishment of its new Community Programs for Clinical Research on AIDS (CPCRA). This initiative, designed to address research questions important to the day-to-day clinical management of persons with HIV infection, will seek to involve community physicians nationwide in AIDS research and provide wider access to experimental therapies. The community programs will operate separately under the national coordination of the NIAID treatment evaluation network which has been conducting collaborative clinical trials of experimental therapies since mid-1986. For more information, please contact Lawrence R. Deyton, M.D., Chief, Community Clinical Research Section, AIDS Program, NIAID, 6003 Executive Blvd., Rockville, MD 20892.

Cholesterol guidelines

The national cholesterol education program (NCEP) of the National Heart, Lung and Blood Institute recently announced publication of its latest continuing medical education independent study monograph entitled "Cholesterol: Current Concepts for Clinicians." The monograph is targeted to practicing physicians, and includes the most recent NCEP treatment guidelines. Two hours of category I CME credit are available upon successful completion of the monograph. For more information, contact the Cholesterol Information Center, 4733 Bethesda Avenue, Suite 530, Bethesda, Maryland 20814; or telephone 301-951-3260.

NLRB loses unionization rule effort in court decision

by Janice Rosenberg

IN LATE JULY, Judge James B. Zagel of the Federal Distric Court in Chicago issued his decision on the American Hospital Association's suit rejecting the rule-making authority of the National Labor Relations Board (NLRB). The suit was filed on April 21, 1989, the same day that the NLRB announced rules authorizing the establishment of eight union bargaining units in any hospital. According to Brian W. Bulger, a partner at Katten Muchin & Zavis, the firm representing the AHA in its suit, the decision "indicates that the judge understood it was a very important case both for the financial well-being of hospitals and also with regard to the NLRB's powers."



Roger T. Bryce



Brian W. Bulger

The judge decided in favor of the AHA. "The judge agreed with us," said Bulger, "that the statute forbade this rule-making." The eight-unit rule, had it been allowed to stand, would have authorized five non-professional units and three professional units: a nurses' unit, a physicians' unit, and a unit for other professionals. The current statute states that the NLRB shall determine the appropriate unit separately in each case. "The judge took this into account," said Bulger, "along with the admonitions Congress has made about the special nature of the health care industry and the need to avoid undue union proliferation."

AHA comments

An AHA spokesperson said, "We don't know what the next step will be. That's up to the NLRB."

Marvin Gittler, local counsel for the AFL-CIO and partner at Asher Gittler and Greenfield, calls the opinion a disappointment. "I believe it misunderstands the balance that the NLRB tried to achieve," he said. "I think it will cause some delay in clearing up the profound confusion that has existed in hospital bargaining unit organizing."

Currently, there is no law in Illinois preventing physicians from joining unions. However, supervisory and managerial personnel are usually excluded from joining labor unions, Gittler noted. Physicians have been designated as supervisory personnel in previous Illinois labor disputes. Gittler explained that it is a conflict of interest for physician supervisors

(continued on page 18)

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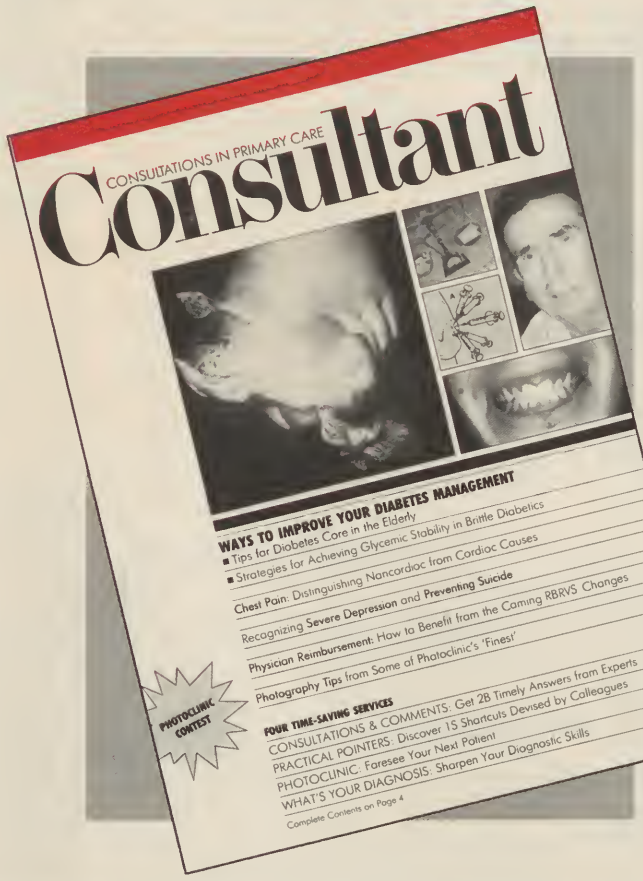
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(OLS continued from page 3)

Jan. 1, 1980 and Dec. 31, 1983, or not less than 24 months of the 48 months immediately preceding Jan. 1, 1984.

Other actions . . . The governor signed into law H.B. 2129, which requires insurance companies to pay for mammograms for female policyholders 35 years old and older. The legislation follows American Cancer Society recommendations for frequency of exams. The mammogram benefit would be subject to copayment and other insurance policy requirements. The legislation affects both individual and group policies.

Thompson vetoed S.B. 273, which would have required Medicare supplement policies also to pay for mammograms. Thompson said that beginning in 1990, Medicare will cover the costs of the procedure for women 65 years old and older.

Thompson also:

—approved legislation authorizing establishment of a registry of head and spinal cord injuries.

—signed H.B. 1425, prohibiting discrimination against graduates of foreign medical schools—legislation supported by ISMS.

—approved H.B. 2062, allowing HMOs to engage physicians not under contract or employed by the HMO to perform up to 10 percent of services delivered to HMO members.

In order for amendatorily vetoed bills to be approved, the governor's proposed changes must be approved by majority votes in both the house and senate. Overriding a veto needs approval by three-fifths of each chamber. ▲

Unionization

(continued from page 17)

representing management to also be members of a union dealing with the employer. Gittler is certain that the ability of employees to exercise their rights will ultimately prevail.

Calling the judge's ruling "narrowly crafted," Gittler stated, "The judge decided against this particular rule, because of the particular circumstances surrounding it, particularly the history of the board's making individualized determinations. The judge specifically found that the board *did* have rule-making authority. He just said that in this case they should not have exercised their authority in the way that they did."

Impact on nurse unions

Sue Oszewski, associate administrator in economic and general welfare for the Illinois Nurses Association, said that her union is waiting to see what the NLRB will do now. "It has always been our intent to organize."

While the judge's decision was pending, the NLRB heard no cases in the health care field. Then on May 19, Judge Zagel issued a preliminary injunction against the planned implementation of the NLRB's health-care bargaining rule, declaring that "the proliferation of bargaining units would destroy the peace and create turmoil in both management-employee and union-employee relationships in the health-care industry."

The Illinois Nurses Association was determined in any case to continue its fight: "In general," said the INA's Oszewski at the time, "hospitals have sought whatever legal means they have to delay and defuse bargaining efforts."

Roger T. Bryce of Sonnenschein Carlin Nath and Rosenthal, attorneys for West Suburban, said that despite the likelihood of an NLRB appeal, the hospital will continue to seek a hearing on this issue. "The board can continue to keep us on hold through their appeals or they can choose to apply the old standards," Bryce said. In his opinion, the old standards, if applied, would make approval of an all-nurses' unit unlikely. "In extraordinary circumstances the union could show that an all-nurses' unit would be appropriate, for example, if the only other professionals in the hospital were the doctors. But West Suburban staffing patterns are usual, with lots of other professionals to be members of a unit with the nurses," he said.

Oszewski disagrees. "For the most part nurses have been organized in nurses-only units," she said. In the Chicago area, University of Illinois, University of Chicago, and Cook County hospitals have nurses only units. "I don't think any of them contain anyone but RNs," she said.

Although Judge Zagel has made his decision, the case is not over. To begin with, the INA is pressing forward in the wake of the July ruling. On October 2, the INA held what West Suburban called a "mock election," refusing to release the results of its non-public organizational meeting to the hospital. Said Amy E. Lively, the hospital's public relations director, "The delays due to federal injunctions were not of our making, and are out of our control. So, it's in our hospital's best interest to let the legal process take its course, and concentrate on providing quality patient care." ▲

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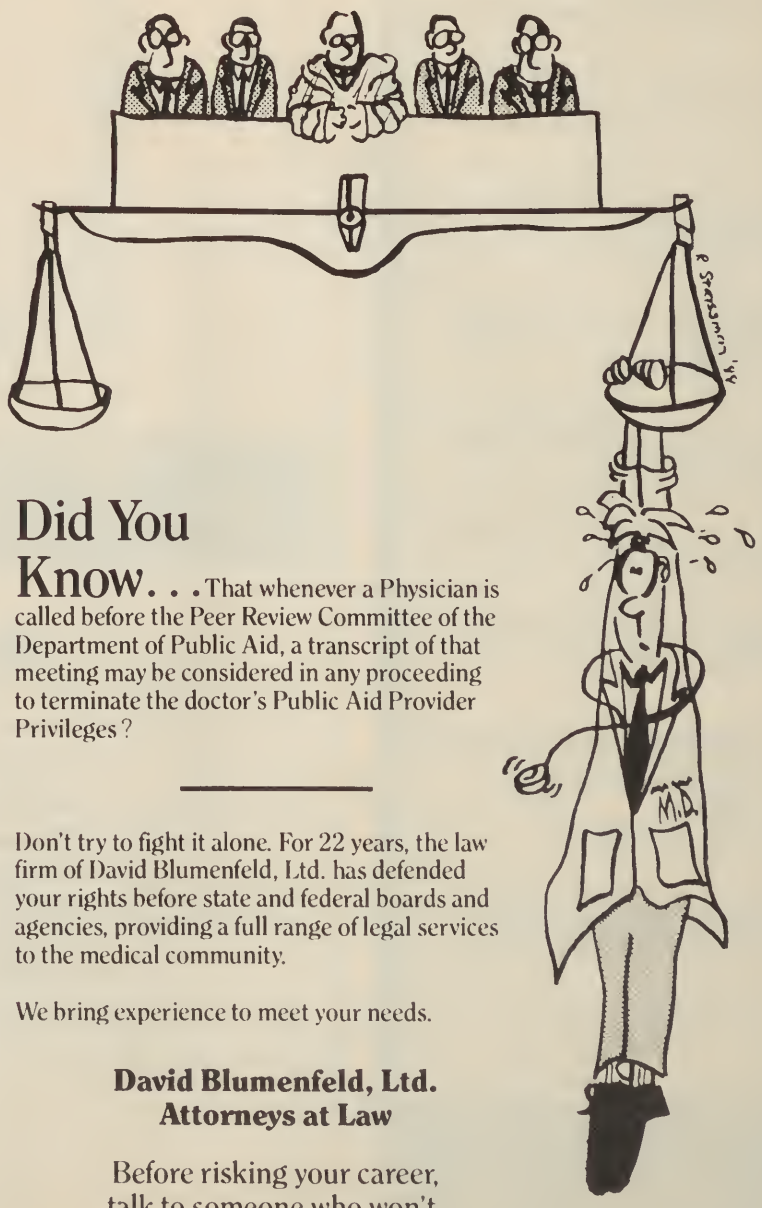
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Illinois Supreme Court agrees to hear certificate of merit case

THE ILLINOIS SUPREME Court agreed October 6 to rule on the legitimacy of the certificate of merit required to file medical malpractice lawsuits in Illinois.

The case reaching the court, *DeLuna v. St. Elizabeth's Hospital and Michael Treister, M.D.*, is one in which justices have already granted permission for the Illinois State Medical Society (ISMS) to file an *amicus curiae* brief in support of the appellant. The decision to hear the case followed a first district appellate court (Cook County) ruling June 13 that the certificate was unconstitutional.

The *DeLuna* case centers on a law applying to all Illinois medical malpractice cases. The law requires the plaintiff's attorney in a medical malpractice action to file a physician's report stating there is reasonable and meritorious cause for filing suit. An affidavit attesting to the physician

(continued on page 7)

Abortion issue embroils Illinois

by Caryl Carstens

ILLINOIS PROPONENTS of tighter restrictions on abortion fell one vote short of pushing their proposal out of committee and onto the Illinois House of Representatives floor October 17.

The House Rules Committee vote made it less likely—but not impossible—that the full House will debate the issue of abortion restrictions during Governor Thompson's fall veto session, which will conclude November 2. As *Illinois Medicine* went to press, pro-life advocates were plotting strategy for reviving the legislation.

Under House rules, a minimum of 10 votes are needed for legislation to reach the floor from the Rules Committee; the October 17 tally was 9-8 favoring release, with one abstension. The Rules Committee allows a bill's sponsor to call for a second vote, and such a vote could take place the week of October 30. A second failure would effectively kill the proposal until the spring General Assembly session.

The proposed Illinois restrictions, contained in H.B. 574, require fetal viability testing of women seeking abortions who are believed to be at least 20 weeks pregnant, the presence of a second doctor to assist a fetus surviving an abortion, a ban on the use of public facilities and employees in elective abortions, and criminal penalties for doctors who violate the regulations, including 2-5 years in prison and fines of up to $10,000.

Following the October 17 committee defeat, supporters of restrictions on abortion defended the urgency of their proposal. "It's a matter of life and death," said Rep. Penny Pullen (R-Park Ridge), the bill's sponsor. "I can't imagine anything more urgent than the life of an unborn infant." Pro-choice advocate Rep. Barbara Flynn Currie (D-Chicago) countered, "There is no emergency. Abortion, after the point of viability has

(continued on page 14)



Wm. Daniels/The Photo Partners

Four prominent Chicago physicians called a press conference to criticize Illinois regulations governing abortion. They are (L to R) Melvin Gerbie, M.D., Marilyn Fredericksen, M.D., Arthur Herbst, M.D. and George Wilbanks, M.D. Story on page 14.



Tuscola, a small community located 25 miles south-west of Champaign-Urbana, is considering closing its only hospital.

A November 7 referendum will decide the hospital's fate.

Photo: David Porter

Small Illinois town reaches the brink in hospital dispute

THE DOUGLAS COUNTY Board had had enough.

Norman Willoughby moved to place the referendum on the November 7 ballot.

Alan Michener seconded the motion.

The deputy of the county clerk's office then called upon each board member.

All eyes were on the scoreboard.

Yeas 4, nays 3.

"The motion carries," declared Virgil Luth, Douglas County board chairman.

And so it was decided August 28: the fate of the county-owned hospital, which had sunk into deep financial waters, would now be in the hands of the people.

Tuscola lies some 25 miles southwest of Champaign, a town of less than 5,000 people in Douglas County, population 20,000, primarily a farming area. It is home of the 73-year-old Douglas County Jarman Memorial Hospital. The county itself and two chemical plants located on the outskirts of the city are Tuscola's three largest employers.

"It's been home for me for 20 years—a nice town. We've got everything here," says Dianna West, a telecommunicator for the Douglas County sheriff's office. "There's a few things you've got to go out of town for, but the people are friendly and helpful. It represents the heartland of America."

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Calling all doctors!

Downstate doctors' fair puts out the welcome mat

by Caryl Carstens



The eleventh annual Doctors Fair was held September 8 on the grounds of the Southern Illinois University School of Medicine in Springfield. (Photo courtesy of S.I.U. School of Medicine.)

COMMUNITIES SEEKING physicians used everything from video displays to a drawing for tickets to a Cubs-Cardinals baseball game to entice young doctors and medical students at the Southern Illinois University Doctors Fair Sept. 8.

The 11th Doctors Fair held by the SIU School of Medicine in Springfield attracted a record 61 groups seeking young physicians. Hospitals, clinics and chambers of commerce sent representatives, while the communities involved ranged from towns like Oquawka, population 2,000, a Mississippi River town in northwestern Illinois, to larger metropolitan areas like Peoria, Rockford and Rock Island.

Staffing needs represented at the fair ranged from basic care physicians for underserved communities to specialists required to round out already-growing staffs. Often, many of the communities present sought young physicians to replace local doctors now within a few years of retirement.

About 200 medical students and residents, most from SIU and other midwestern medical training programs, visited booths set up in the large tent adjacent to the medical school campus. Springfield's Memorial Medical Center was host, providing the site and lunch for attendees.

Jim Thomas, M.D., an SIU resident in otolaryngology, said he was just beginning to look for a location in which to practice when he completes his training in about 18 months. But he would be an unlikely candidate for many of the smaller or medium-sized communities represented at the fair.

"My wife also is employed, so we will be looking for St. Louis or Chicago," Dr. Thomas explained. She is a technician, trained to operate a gait laboratory, and he is looking for a large city in which to practice his specialty.

None of the community representatives expected to sign up a physician immediately; instead, recruiters saw the fair as a first step in the long process of physician recruitment, which often requires months or even years to complete.

"You have to have some exposure," explained Sam Lay, administrator of Passavant Hospital, Jacksonville. "We found you develop contacts" that over two or three years result in recruitment of a new physician, he said.

Jacksonville is a 20,000-population county seat of a predominantly rural central Illinois county. Like many such communities, it must prepare for the retirement in a few years of its older and more experienced physicians by recruiting younger doctors.

"We need almost everything," said Sandra Barkley, physician relations coordinator of the Sara Bush Lincoln Health Center in Mattoon. That eastern Illinois hospital serves both Vandalia and Mattoon.

Barkley believes the relative isolation of the Mattoon-Charleston area makes it difficult to recruit physicians. It isn't near major metropolitan areas like Chicago or St. Louis, though Champaign-Urbana, site of the University of Illinois, is only 45 miles away. Charleston is also the home of Eastern Illinois University.

Ann Heath, M.D., a young family practice physician practicing in Clinton, west of Champaign-Urbana, was part of the team recruiting for the John Warner Hospital. She said many communities help young physicians pay off medical education loans as a recruitment incentive. Other communities provide income guarantees.

But in general, recruiters at the SIU fair weren't stressing the subject of income prospects, said Jon Cumberledge. "They talked about being of service to the community." Cumberledge, a third-year medical student hopes to set up a small-town practice.

Lyle Vanzandt, director of physician services at Marshall Browning Hospital, DuQuoin, was not optimistic about his chances of recruiting a new physician. Over the past 10 years, the hospital has recruited one physician, he reported.

"We really don't expect much more than that," Vanzandt said. DuQuoin is a southern Illinois town of about 6,500. The area is more fortunate than most in southern Illinois because the medical community includes an obstetrician. Large areas of southern Illinois are reported to have no OB physicians available. There also is one family practitioner in DuQuoin who takes obstetrics cases.

Vanzandt hopes to recruit another family practice specialist who also would take obstetrical cases. The community now has seven physicians,

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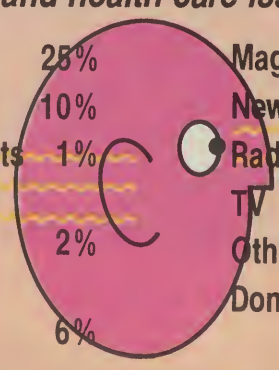
Corrections and clarifications

In the September 1 *Illinois Medicine* issue, Gerald D. Suchomski, M.D., was identified as practicing in Springfield. Dr. Suchomski is the program director at the SIU School of Medicine's Belleville Family Practice Residency Center in Belleville.

Joseph Daw, M.D., current president of Crescent Counties foundation for Medical Care, was incorrectly identified in *Illinois Medicine* (August 18, 1989) as an internist. His correct specialty is family practice.

Physician Facts

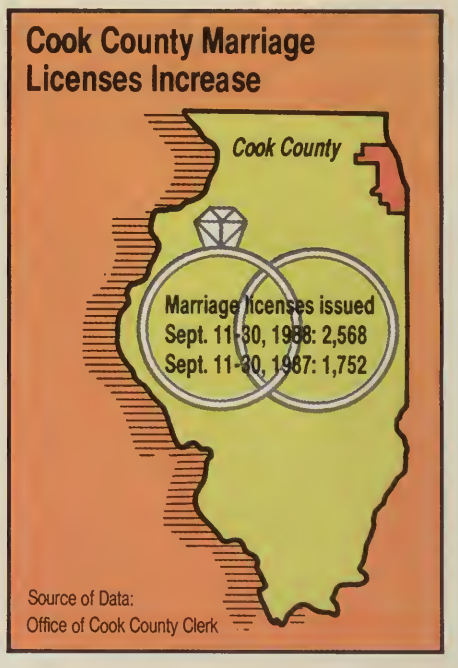
Where do patients receive most of their information about health care and health care issues?



Doctor/Dr.'s Office	25%	Magazines	16%
Hospitals/Clinics	10%	Newspapers	17%
Pharmacists/Druggists	1%	Radio	1%
Other Health Care Professionals (Nurses, etc.)	2%	TV	9%
		Other	10%
Family/Friends	6%	Don't Know	3%

Source of Data: Illinois State Medical Society Public Opinion Survey, August 1989.

Marriage licenses boom after AIDS test repeal



THE NUMBER of marriage licenses being issued in Illinois has risen dramatically since Governor Thompson repealed the premarital AIDS testing law September 11. From then until the end of September, the Cook County Clerk's office issued 2,568 marriage licenses, compared with 1,752 for the same period last year, according to Cook County Clerk Stanley Kusper.

Kusper said it remains unclear whether the 46-percent increase from a year ago is "because people were anticipating the governor to sign the repeal and waited to get their licenses, or whether it reflects an increase in the number of people getting married." He added, "A longer period of review will give us the opportunity to do statistical comparisons."

Premarital testing began January 1, 1988. Critics said the testing requirement was costly and ineffective, while Cook County officials maintained Illinois border counties suffered a 20-percent loss in revenues because of the high number of couples marrying out of state.

The Illinois State Medical Society (ISMS) has consistently opposed the premarital AIDS test law and worked for its repeal. ▲

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On the legislative scene



During the October 17-November 2 veto session, state legislators are considering several health-related bills Gov. James Thompson vetoed or amendatorily vetoed last spring.

FDA-approved drugs . . . The governor vetoed H.B. 506, which would have required physicians to seek informed consent from patients when prescribing FDA-approved drugs for "experimental procedures." The bill defines such procedures as "all uses of medications which are not specifically listed in the FDA labeling." In vetoing the bill, Thompson said, "The FDA does provide information on the uses of approved drugs in clinical trials, but does not approve or disapprove drugs for specific uses." ISMS opposed the bill, adding that "physicians are not legally bound to abide by the FDA official drug labeling, nor do the dictates of sound medical practice require that they do so." The House overrode the governor's veto October 17.

X-ray requirements . . . Thompson returned an amendatory veto on H.B. 2351 which would have allowed physicians to certify the competence of their staff members who take x-rays, if such staffers met certain requirements for prior experience. ISMS supported the original legislation. Thompson's amendments would call for x-ray techs to have at least three years of experience prior to Jan. 1, 1980 and not less than 12 months between Jan. 1, 1980 and Dec. 31, 1983, or not less than 24 months of the 48 months preceding Jan. 1, 1984.

Cocaine addiction . . . The governor amendatorily vetoed S.B. 613, which would have required pregnant addicts to participate in the Department of Alcoholism and Substance Abuse (DASA) program. Thompson proposes the bill be changed to make the program voluntary instead of mandatory. ISMS objected to the bill because mandating such requirements could dissuade addicted, expectant mothers from seeking medical care. The Senate accepted the amendatory veto October 17. The House is expected to review the legislation October 31.

Thompson had also amendatorily vetoed S.B. 1413 which would require a doctor to refer pregnant women who are addicts to DASA. Thompson's proposed amendment would make it applicable only to women receiving Medicaid. The Senate passed the amendatory veto October 17.

Malpractice premium assistance . . . The governor vetoed S.B. 1303, which would have helped obstetricians and family practice physicians in rural areas to pay their malpractice insurance premiums. While the rural health program as a whole passed the legislature last spring, the General Assembly provided no funding.

Chicago to study clinics, trauma system

by Kevin O'Brien

WITH an eye on the Cook County health care summit scheduled to begin Nov. 3, Chicago Mayor Richard M. Daley and his acting health commissioner Richard M. Krieg, Ph.D. announced initiatives to address two of the city's most pressing health care problems: its crumbling clinic system and the under-financing of its trauma network.

During an Oct. 18 mayoral press conference, Dr. Krieg announced the formation of two committees to develop recommendations on these two issues. Chairing a 17-member Clinic Oversight Committee will be Mercy Hospital President and Chicago Board of Health (CBOH) member Sister Sheila Lyne. The 16-member Trauma Steering Committee will be chaired by CBOH member Susan Manilow, a trustee of the Mt. Sinai Hospital and Medical Center.

The committees will use two new Chicago Department of Health reports as the starting point for their deliberations. The 44-page *Clinics in Crisis* describes a system that is "designed for failure," because it lacks the personnel, equipment, and physical plant to adequately care for the annual one million patient visits it currently accommodates.

A 20-page report, *Trauma Care in Chicago,* says that although Chicago's system is basically sound, caring for Level I trauma patients in Chicago resulted in an approximately $10 million loss for the participating medical centers during 1988. Dr. Krieg said that only five of the country's 21 largest trauma systems currently operate in the black.

Chicago's trauma network originally had 10 adult trauma centers and five pediatric centers. However, since the network was formed in 1986, Weiss Memorial Hospital, the University of Chicago Hospitals, and the Loyola University Medical Center have dropped out of the system. Last winter, Michael Reese Hospital and Medical Center announced it was dropping out, but reversed its decision while it was pursuing its affiliation plans with the University of Illinois. ▲

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

MEDICARE NOTES

Subject: Reminder Elective Surgery — Notification to Patient

1. Notification of physicians' fees and the patient's financial responsibility must be presented to the patient in writing prior to surgery when assignment is not accepted.

2. This requirement applies to all elective procedures ranging in price from $500 and up, and to the services of the surgeon, assistant surgeon, and anesthesiologist, for *surgical* procedures, (Type of Service *2*).

3. The notification to the patient must be signed and dated by the patient.

4. The appropriate calculation must be done for the patient and included in the notification to the patient.

Subject: Epogen

Effective for dates of service July 1, 1989 and after, Epogen is covered when administered intravenously or subcutaneously to patients suffering from anemia associated with end stage renal disease (ESRD). The patient must be on dialysis for the coverage criteria to be met.

Billing instructions will follow at a later date and Epogen claims should be held until the instructions are received.

Subject: Food Allergy Testing and Treatment — Not Covered

Effective for dates of service October 31, 1988, and after, sublingual intracutaneous and subcutaneous provocative and neutralization testing and neutralization therapy for food allergies are excluded from Medicare coverage because available evidence does not show that these tests and therapies are effective. This exclusion was published as a Final Notice in the *Federal Register* on September 29, 1988.

Subject: Cardiac Output Monitoring by Electrical Bioimpedance — Not Covered

Cardiac output monitoring by electrical bioimpedance (procedure code Q0066) is excluded from coverage at this time. It is not a widely accepted and established diagnostic modality and is still investigational.

Electrical bioimpedance is a non-invasive method of using two pair of electrodes placed on the thorax of the patient to determine stroke volume and cardiac output based upon the electrical impedance of the thorax to an externally imposed electrical current. The potential effect of long-term electrical bioimpedance has not been studied and the precision and accuracy of the technique in severely ill patients has not been compared to invasive techniques.

(This report is a service to the physicians of Illinois)
10/27/89

Editorials

Certificate of merit: worthy concept on trial

The Illinois Supreme Court has agreed to rule on a question of vital importance to Illinois physicians and their patients. The certificate of merit for medical malpractice cases, ruled unconstitutional June 13 by a Cook County appellate court, was earlier upheld in three other Illinois jurisdictions; now, the state's high court will be asked to clear up the conflicting rulings.

The DeLuna case involves a clear conflict of social good versus law. On the one hand, the certificate of merit requirement, established in 1985 by the Illinois legislature and refined in 1989 (to require that the physician certifying the legal merit of a medical malpractice case be a specialist in the same field as the defendant physician), has cut down drastically on the number of malpractice cases reaching trial. On the other hand, said the appellate court, putting that sort of gate-keeping authority in the hands of physicians amounts to the transfer of judicial power to non-judicial personnel.

The Illinois State Medical Society supports the law as it now stands. The certificate of merit has minimized the onrush of non-meritorious malpractice suits, breaking a serious bottleneck in the legal system that was forcing truly injured patients to wait for compensation. Should the requirement be repealed, the number of meritless claims and suits would immediately spiral upward, once again clogging the courts and re-establishing an unfair system of compensation.

We hope the court realizes the expensive and injurious consequences that finding the certificate of merit unconstitutional would have. ISMS intends to argue that point when the court examines the issue this term.

They heard it through the grapevine

The good news, according to an Illinois State Medical Society poll taken in August, is that patients are getting a good 38 percent of their medical information from medical professional sources—doctor's offices, hospitals, clinics, and pharmacies. The bad news is that patients are getting the remaining 62 percent of their medical information from somewhere else—as the chart on page two clearly demonstrates.

That means doctors need to strengthen their efforts to provide patients with the best medical information available—at the ideal source, the doctor's office—or through the variety of local community-outreach opportunities available to MDs. If we want our patients to make informed health care choices, we must make an investment in communicating vital information to them—both as individuals and as groups. ▲

Illinois Medicine

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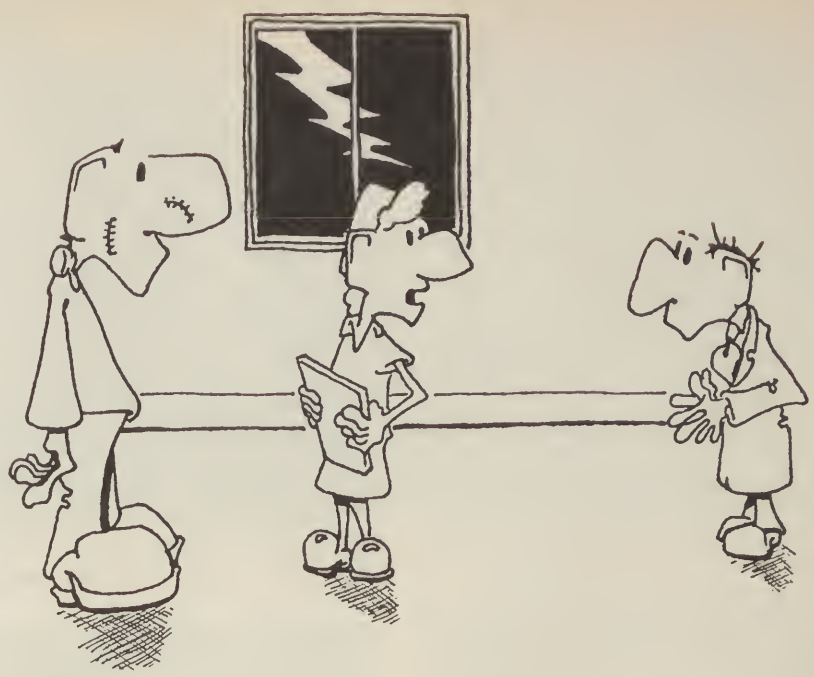
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"I'm sorry Dr. Frankenstein, but he insists on seeing only you."
Source: Humeri

Guest Editorial

When the cast is on the other foot



by Morgan Meyer, M.D.

Being a patient isn't easy, especially when you're a physician. Not long ago, I underwent surgery that involved radical neck dissection. I was admitted for five days to Elmhurst Memorial Hospital in Elmhurst, where I have practiced as a physician for over 30 years.

As a doctor, I felt firsthand the anxiety that my expert knowledge of complications and infections produced. I worried about the difficulties I know patients face with certain treatments. Although I'd been a patient several times before, it was tough to surrender the control I was accustomed to exert as a physician.

Through the years I've also treated physicians. And I've come to realize that we as a group are trained to be critical of the care we and others administer. But a constantly critical eye to the caregiver only results in heightened tensions. It can be counterproductive to a patient's well-being.

We're used to "running the show" and try to do so from bed. Instead, we should resist that notion, putting some of our knowledge and concern aside and allowing nurses and doctors to help us. The temptation to give a "know-it-all" performance is always there; but we should remember that our caregivers may be apprehensive, to begin with, about treating us "experts." A few simple words to relax the situation can make everything a whole lot easier.

From the treating perspective, nurses and doctors often assume their MD patients know all about medical procedures. But because there are so many narrowly specialized physicians and nurses, MD patients need to be cared for like all other patients. An ophthalmologist, for example, may not know everything about a broken leg; nor will an internist necessarily be familiar with some surgical procedures. Those providing the care should discipline themselves to go through *all* routine instructions, providing the usual warnings of possible complications. A physician admitted to the cardiac care unit should be given the usual cardiac instructions. Routine surgical precautions should be outlined for a patient physician admitted to the surgical unit.

Before my most recent hospital stay, I took myself aside and realized that *I* was going to be the patient. Somewhat to my surprise, receiving care proved a truly heart-warming experience. It further reinforced my belief that we must continue to remind ourselves, as we do our patients, of the importance of maintaining trust in our health care providers. The vast majority of the nurses and doctors who treat both us and our patients are caring, well-intentioned and highly competent professionals. ▲

Dr. Meyer, of Lombard, specializes in internal medicine.

Illinois Snapshot

Would you be willing to pay another $25 a year to keep Douglas Jarman Hospital open?

*Those questioned were told that the $25 estimate was based on a $40,000 home with a $3,333 owner-occupied deduction (an assessment of $10,000).**



Marie Howard, Villa Grove
Retired

"I don't want to do that. A little over $2 a month. That wouldn't be too bad. I just don't want to raise my taxes."



Richard Smith, Tuscola
Operator at Quantum Chemical Co., USI Division

"No. I believe that Jarman was over-built and is over-staffed and should be able to make it on the number of patients listed in their advertising. There has to be a door to stop the continuing losses."



Marlys Fidler, Arcola
Farm wife

"I think we should keep it. You get better care there . . . it's personalized care. It's not right that some insurance companies make you go to certain doctors in Champaign. And how are you going to get a horse and buggy to Champaign? These Amish around here need it."



Bruce Wood, Tuscola
Pharmacist

"Twenty-five dollars isn't that much to keep a hospital with the conveniences we have here for emergency situations and the elderly. We have to remember our older folks can't always make a trip to Champaign. A lot of people don't feel as at-home in a larger hospital, and the care at this hospital is superior to the quality given at Carle or Mercy. My only problem with the $25 is that it's not going to solve the problem."



Jean Bowles, Tuscola
Certified nursing assistant (never worked at Jarman)

"Yes. What would we do if we had to go to Champaign or something? It's just crazy to try to go to Champaign in an emergency. What's $25 compared to a life? All my kids were born there. My husband was born there, and we need it. My husband's family was also related to the Jarman's."

**Text and photos by David Porter of Tuscola.*

Challenges & Choices for the 1990s

The Illinois State Medical Society's All Member Conference

November 17 & 18, 1989
Hyatt Regency Oak Brook Hotel,
Oak Brook, Illinois



Medicine in Congress
9:00 a.m.
Saturday, Nov. 18
Harry Schwartz, Ph. D., a regular contributor of health care topics to the *Wall Street Journal* and *American Medical News,* will discuss medicine's future in light of expenditure targets and other federal proposals that cap health care expenditures.



The Canadian & U.S. Health Care Systems
11:30 a.m.
Saturday, Nov. 18
Hugh Scully, M.D., of the Canadian Medical Association, compares the two systems.

For registration information, write or call:
Illinois State Medical Society
20 N. Michigan Av., Suite 700
Chicago, IL 60602
(312) 782-1654 or
(800) 782-4767

Part one of a two-part series

ISMIE brings affordability, security to Illinois doctors

by Eileen Norris

IN THE beginning, there was frustration and anger. Then panic set in. The reactions weren't out of line considering the news: a majority of the state's physicians faced a whopping 367 percent premium increase for their medical malpractice insurance.

It was February of 1976 and the proposed increase by the Illinois State Medical Society's (ISMS) sponsored carrier would take effect five months later in July, affecting 7,000 practitioners.

There was no time to lose. Not only was affordability a big concern; the bottom line was having the coverage available. Without it, doctors couldn't practice.

An ISMS negotiating team was able to talk the carrier into whittling down the increase to 278 percent, but it soon became abundantly clear that the insurer, faced with a steady stream of big-ticket lawsuits, really didn't want the doctors' business anymore. In effect, it was pulling out of the state. Now what? The handwriting was on the wall, but it was scrawled in a shaky hand.

"We had to go into the insurance business," explains Phillip Boren, M.D., who was chairman of the medical society's insurance committee at the time. "We had no other option," he says of the events that led up to the crisis.

"It was a real loomer," recalls Fred Z. White, M.D., chairman of the Illinois State Medical Inter-Insurance Exchange (ISMIE). "Many of us had realized the frequency and severity of suits had increased, but you can't translate the general knowledge of that into a huge premium increase, and we were shocked. It was intolerable and unaffordable."

ISMS hired its own actuary to compute a premium increase that doctors felt they could live with, and one that would allow the medical society to bankroll its own physician-owned insurance company.

Some doctors no doubt remember paying a 178 percent increase in 1976, a sum that included the $25 million in contributions needed to get the company up and running. Nevertheless, the increase was considerably lower than the carrier's proposed hike, and insurance was available, so a real crisis was narrowly averted.

"The idea at the time was that we would set up an insurance company using professional people and function as a proper state-chartered company," says Robert C. Hamilton, M.D., chairman of the board of directors of the Illinois State Medical Insurance Services, Inc. "But the ultimate policy- and decision-making would be made by the physicians."

The responsibility was awesome, all agreed at the time, but in reality physicians had been unhappy with their commercial carrier for some time. Here was the chance to change things.

It wasn't just the staggering premium increase the carrier had proposed that upset doctors. Many were also unhappy with the policies and behavior of the insurer. In fact, some doctors had their coverage dropped without good reason; moreover, many doctors were unhappy with the insurer's propensity to settle claims without the policyholder's knowledge or permission.

"One thing that was really upsetting to physicians was that the commercial carrier was paying off claims just to get rid of them," recalls Dr. Hamilton. "Many times it was without regard to culpability.

"And in many cases, the insurer never informed the doctors that such action had been taken. Often, the doctors knew they hadn't behaved differently than they should have," he adds.

When ISMIE was started, the physician founding fathers agreed that its creed would contain several basic principles. One of the most adamant promises then—and today—was to provide a vigorous defense for doctors with nonmeritorious claims, says Dr. Boren. "That represents the vast majority of all claims that are filed against doctors," he hastens to add.

ISMIE and its 10,000 policyholders are entering their 14th year of operation together and despite some tough times common to any new company doing business, the Exchange has proven its staying power.

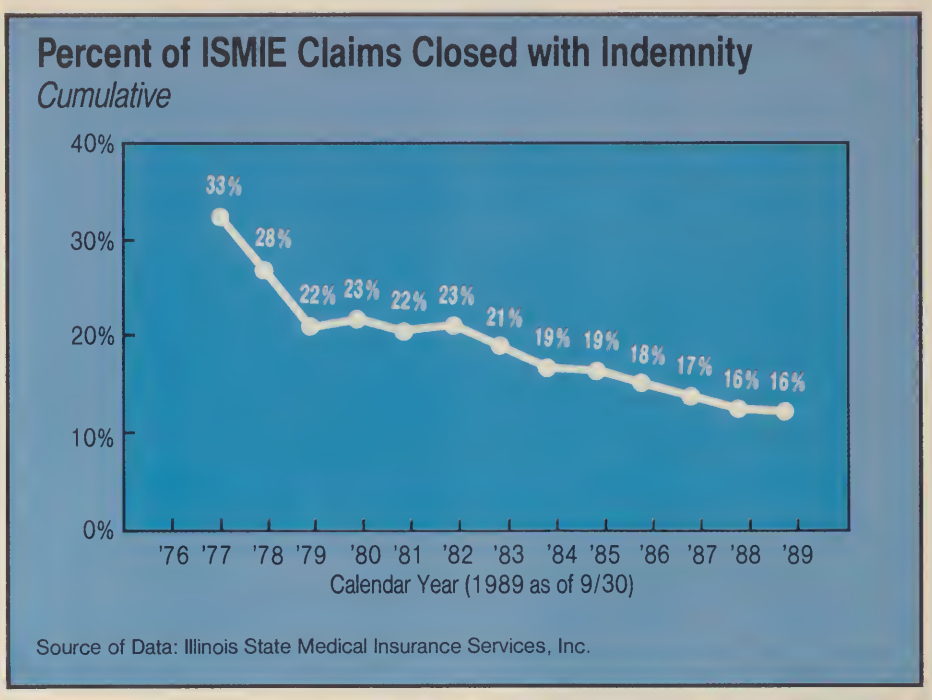
ISMIE in the early years

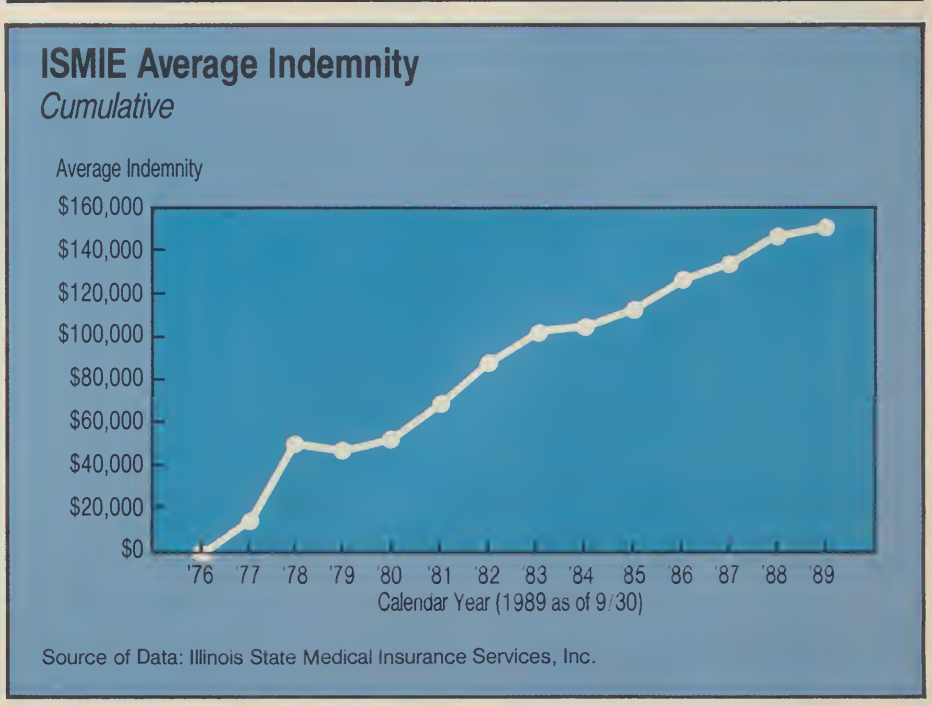
In 1977, a year after the Exchange was operational, there were only 170 claims against policyholders, with the average payout at less than $16,000. In 1978, claim activity began to pick up, with 650 claims pending at the end of the year and the average indemnity jumping dramatically to $80,000.

By 1979, premium increases averaged about 5.5 percent and the Exchange realized a $6.6 million surplus. But claim payments in 1979 had doubled from the previous year to $2.5 million, and the number of cases tripled to more than 1,600.

By 1980, with the overall legal situation worsening, the Exchange asked for a 14.5 percent average premium increase, but claims were up 23 percent over the previous year and the Exchange became more aggressive in trying to control losses.

Membership continued to grow in 1981, and so did the average premium; up about 11.6 percent from the previous year. The Exchange became the seventh largest malpractice insurer in the U.S. and the second largest physician-owned insurer, with 8,500 policyholders.





In 1982, commercial carriers who had fled the market during the crisis years appeared back on the scene, taking about 100 Exchange-insured physicians with them. Continual losses necessitated a premium increase of about 20 percent. Loss experience caused the Exchange to incur its worst decrease in surplus to date—$10.8 million.

The Exchange was going through some tough times, and in 1983 it experienced another decrease in surplus, this time $9 million. To make matters worse, total indemnity payments on claims were up 23 percent, forcing an average 23 percent premium hike.

Things didn't get much better in 1984, and the legislature adjourned with no action on tort reforms proposed by ISMS and the Exchange. A grassroots lobbying effort was formed to get action in the following year, but in the meantime, policyholders experienced another premium increase, this time about 11.5 percent.

After the tort reform of 1985

The year 1985 was a watershed for the Exchange. Meaningful legislation was approved, including structured payment of large verdicts; easing of prohibitions against counterclaims; abolition of punitive damages; limits on attorney contingent fees; itemized jury verdicts; expert witness requirements; and easier dismissal of uninvolved defendants.

Unfortunately, passage of effective tort reform prompted a flood of malpractice claims by plaintiffs trying to beat out the effective date of the new law.

By year-end, 9,356 claims were pending, some 27 percent more than the previous year, with the average indemnity payout topping $160,000, a new high. Nearly $53 million was paid out on 327 claims. The claims climate led to the Exchange's largest premium increase, an average 30 percent—and its worst reduction in surplus to date—$20.8 million.

An increase in surplus for the first time since 1980 and a reduction in claims filed made 1986 more upbeat.

The Exchange investment portfolio was hardly touched by the October 1987 financial chaos. The Exchange investment program is conservative and structured to ensure that funds are available when they are needed to pay losses.

In 1988 the Exchange's strong financial condition allowed it to refund the remaining guaranty fund certificates, which totaled $16 million.

The Exchange has spent the years since 1985 building an effective defense team and defending key elements of Illinois' tort reforms, which have faced several legal challenges. ▲

EDITOR'S NOTE: Part two of this article will appear in the next issue of Illinois Medicine.

DeLuna

(continued from page 1)

consultation must accompany the physician's report; failure to file the report and affidavit results in dismissal of the case. Passed in 1985 as part of ISMS-backed comprehensive medical malpractice reform legislation, the requirement is credited with the large decline in lawsuit filings following its enactment.

"The [appellate court] decision," said ISMS president Eugene P. Johnson, M.D., "was a significant setback for the 1985 medical malpractice reforms achieved by the medical society. ISMS stands ready to help restore this reform," he added.

ISMS had asked the Illinois State Bar Association (ISBA) and the Illinois Trial Lawyers Association (ITLA) to join in an amicus brief supporting the certificate of merit's constitutionality. Both groups declined to participate, even though ITLA had proposed the original certificate of merit concept. ITLA withdrew support from the requirement proposal by the time it was adopted in 1985, as the bill had evolved significantly in the legislative process. ISBA has never taken an official stand on the proposal.

"We declined," said Jim Dudley, ITLA executive director, "basically because even at the time the idea surfaced, there were questions in the minds and leadership of ITLA as to whether the measure was constitutional. There still are questions, as is obvious. It is hard to argue with Justice Scariano's opinion that you are turning the keys to the courthouse over to non-judicial personnel."

"Our primary reason in declining support of the amicus," said David Anderson, ISBA director of public relations, "was we had no position on the original legislation. We pretty much stayed on the sidelines during the 1985 legislative debate."

In *DeLuna,* the plaintiff filed suit without a certificate of merit, and the trial court dismissed the case. On appeal by the plaintiff, the appellate court reversed, saying the certificate requirement "takes away from the court altogether a vital decision-making function and confers it upon the members of a private professional group who hold in their hands the keys to the courtroom itself."

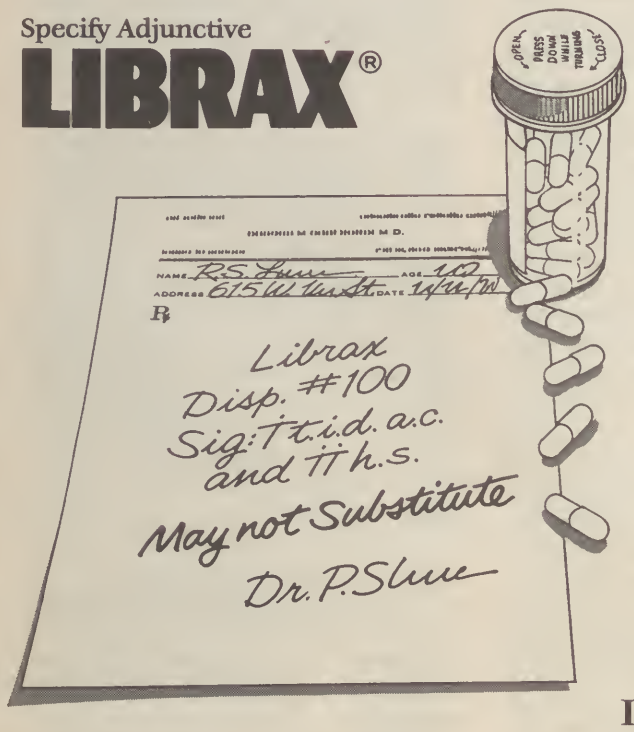
The court also said that, by mandating the certificate, the legislature had intruded into judicial authority.

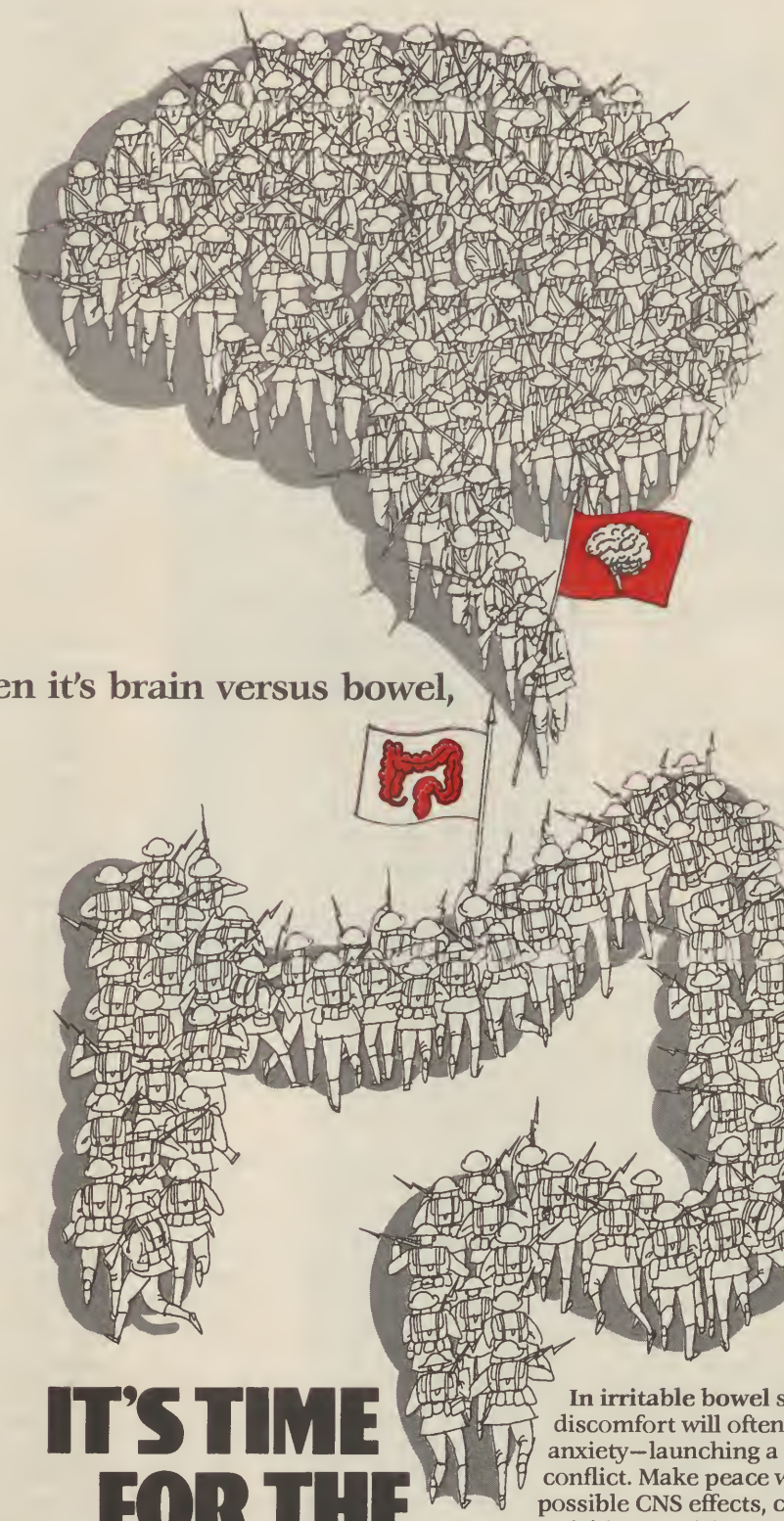
"The state's high court," said ISMS general counsel Saul J. Morse, "is now faced with a clear conflict to resolve, as three other Illinois federal appellate courts have upheld the certificate of merit's constitutionality, while the first district has struck it down."

A decision on the case is expected by sometime next spring. ▲

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Part three of a series

PRO utilization review: MDs walk Medicare's "tightrope"



This Illinois Medicine *focuses on the utilization review process of Medicare's peer review organization (PRO) in Illinois, Crescent Counties Foundation for Medical Care (CCFMC).*

"WE DO HAVE TO WALK a tightrope, and I don't know that we're going to be able to get away from that," says Michael Brown, M.D., a member of the CCFMC's physician reviewer oversight committee who teaches MDs how to examine charts for utilization review. A gastroenterologist at Rush Presbyterian-St. Luke's Medical Center in Chicago, Dr. Brown is board-certified in his field of medical practice, as well as in quality assurance and utilization review. He acknowledges, "We physicians have to provide top-notch, high-quality care, and do it in the least number of inpatient days possible. That's a difficult decision, one based on medical judgment."

In fact, that "difficult decision" is at the root of Medicare's utilization review program, which aims to save the government dollars by denying payment for patients' hospital care when reviewers determine that inpatient admission is unwarranted.

While the Illinois PRO denies only 3.9 to 4.5 percent of all the medical records it reviews for utilization, its impact on physicians and hospitals is much larger than those numbers suggest.

"Medicare's utilization program has affected us quite dramatically," asserts Janis Orlowski, M.D., another Rush physician who chairs that hospital medical staff's utilization review committee. She estimates that based on PRO utilization reviews, Medicare denied one million dollars of inpatient admission payments to Rush in fiscal 1985-86, but she did not supply a current estimate. Since then, she adds, Rush has made many internal policy changes to adapt to the utilization review process. "Money is really driving the system," she says.

Utilization review: the process itself

The PRO measures utilization in terms of "the acuity of a patient's illness," according to CCFMC chief operating officer for review services Steve Kaufman. Criteria for determining whether a patient is sick enough to be in the hospital are based on a complex listing of symptoms and treatments needed, grouped within 13 specific body system categories (such as musculoskeletal, respiratory, urinary, central nervous, etc.) plus one generic category applying to all cases. Each of these symptoms or treatments signals the patient's "severity of illness," or the "intensity of service" needed.

If the PRO's nurse coordinator initially reviewing a medical chart fails to find sufficient documentation, the utilization review process begins, with the patient record in question referred to an MD for further scrutiny.

This happens to some 44 percent of the 7000 records CCFMC looks at monthly.

"The physician reviewer in most cases comes to the hospital to review the record," says Mary Kreie, R.N., director of Medicare review services at CCFMC. These reviewers use only medical judgment, she stresses, not the criteria established to guide initial screening by the nurse coordinators. "If the nurse referred the case because the criteria weren't met, the case can still be approved for acute care admission based on the physician reviewer's medical judgment," Kreie explains.

If the MD reviewer has doubts, however, he or she writes a documentation request letter to the attending physician, who is expected to respond within 20 days. Letters to attending physicians are sent out on about half the charts reviewed by the first physician. In the interim, a second (and different) physician review is slated to go over any additional documentation and the attending MD's response. The attending doctor has the opportunity to communicate with that reviewer by phone, in person, or in writing.



Photo: Wm. Daniels/The Photo Partners

Janis Orlowski, M.D.; "Medicare's utilization program has affected us quite dramatically."

However, if a substantive disagreement between the reviewer and attending physician still exists after the second review, payment is denied. A physician or hospital with a pattern of such denials will be evaluated under the PRO's quality review program as well.

"After that, the hospital, physician or the patient can ask for reconsideration," says Kreie. These hearings are held in various Chicago metro-area locations, as well as downstate. "A panel of specialists matched to the specialty of the attending physician reviews the [medical] record, and upholds or reverses the original denial," she adds. Any party affected—doctor, patient or hospital—has the right to participate.

One final check in the system is the provision for appeal to an administrative law judge.

"There's a general feeling we deny more cases than we do," says CCFMC reviewer Dr. Brown. When he explains the actual statistics to MDs and hospitals, "There's quite a bit of surprise that 4.5 percent is the denial rate. Physicians have a much bigger impression. In reality it's a very small number," he says, acknowledging that "Even I get DRG validation problems and utilization denials. There shouldn't be any stigma attached."

Dr. Brown also rebuts the popular notion that physician reviewers use "retrospection when they review the chart and see that what happened to the patient turned out to be not so bad. They're not to use the outcome to determine whether the patient needed admission," he emphasizes, "but simply the [medical information] the attending physician had facing him when he had to make the decision to admit." In fact, federal law governing state PROs requires that the reason for admitting the patient—and not the patient's discharge status—be the chief focus of utilization reviews.

Coping with utilization review

Coping with bureaucracy, as well as with the adversarial nature of the review process, is something Dr. Orlowski and her medical staff utilization review committee have learned to do through years of interaction with CCFMC.

As a result, Rush has instituted a "physician representative" program to help attending physicians respond to PRO probes. "Oftentimes the PRO is looking for a 'buzzword,' such as 'intensity of services maximized,' in the attending MD's response. So we have trained physicians to help their colleagues respond," says Dr. Orlowski.

Since the program's onset, payment denials at the hospital have dropped off precipitously. "We went from a denial rate of about 80 percent by the second physician reviewer to 20 percent," according to Dr. Orlowski.

These MD advocates are paid to help with utilization response letters, meet personally with reviewers and appear at reconsideration hearings if necessary. "Personal contact with the reviewer is better than anything," she advises, adding that when physician reps are not able to do so the denial rate soars back up. "We have to be vigilant," she says. The attending doctor can participate alongside the physician representative if he or she chooses. "Then, we're there for support."

With utilization review here to stay, Dr. Brown advises that physicians get used to it, "by understanding what types of DRGs are causing their hospitals and themselves problems, and spend some time clearly documenting the need for admission [upfront]."

"It's the vague abdominal complaints, the patient with the low back pain, the short stays," that generate the utilization questions, adds Kreie.

Most agree, however, that the utilization review process is getting more comfortable with age. Alfred J. Kiessel, M.D., Illinois State Medical Society (ISMS) trustee and consultant to the organization's Council on Economics, believes, "It's a learning process." He says the number of denials "should progressively decrease as doctors get more attuned to the PRO's utilization review process." ISMS and hospital medical staffs around the state have reviewed the criteria and provided extensive input to CCFMC.

Dr. Brown adds that physicians shouldn't hesitate to voice concerns or problems with the screening criteria. "Doctors should familiarize themselves with them. If a physician reviews the criteria for the patients he or she admits and doesn't think they are fair, a letter to both the Health Care Financing Administration (HCFA) and the PRO are indicated. This is a responsive system. The screening criteria are evolutionary, not set in stone," he asserts.

Observation units: a partial solution?

Before this year, any hospitals holding a patient not sick enough to warrant inpatient admission in an observation unit for more than 24 hours risked having their payment denied. Now PRO reviewers instead look at "the need for acute care hospitalization as the trigger for inpatient admission—not the length of time in an observation unit," according to Kreie. Before the change, Kreie estimates that some 20 cases per month were denied, "with a monetary loss to the facility."

Dr. Brown terms the new flexibility of Medicare's observation unit rule as "ideal for physicians who were using the acute care admission for observation. Those one- or two-day inpatient stays were invariably the kind that got denied, he adds. He believes there's still quite a bit of underutilization of those observation units.

But Dr. Orlowski offers a contrary view. "We usually either admit them or don't admit them. We have not found the observation unit to be that much of an advantage, because its use cannot be pre-planned." According to Dr. Orlowski, Medicare prohibits this, which makes it very difficult for the hospital to have appropriate staff and nursing resources available.

"In a teaching facility like ours, we're concerned about attending [physician] and resident coverage. If you put someone in a 24 hour unit, you're always on the edge of whether they should really be in a monitored bed." She feels the observation unit is strictly a monetary concern of [Medicare's], and has serious questions about the quality of medical care.

Hospitals: the big losers

When inpatient admissions are denied by the PRO, hospitals stand to lose big dollars, at a time when, according to the Illinois Hospital Association (IHA), they are already losing an average 11 percent for each Medicare patient generally. That leads to pressure on attending MDs who control the inpatient admissions.

"Nobody's happy in the current

(continued on next page)

DRG 243: utilization review's impact

In 1985, Chicago's Rush-Presbyterian St. Luke's Medical Center had about 800 admissions under DRG 243, which defines payment for "lower back pain," says Janis Orlowski, M.D., who chairs the medical staff's utilization review committee there. That number dropped to 300 last year, after the committee looked at ways to counteract the PRO's focus on DRG 243, and what she terms the "substantial" PRO denials Rush had received for those patients.

"We spoke with rheumatologists, orthopedists and neurosurgeons—anyone who deals in low back pain, and came up with a number of new very stringent criteria [for admission]. We'd learned our lesson."

Recently, however, questionnaires were sent to MDs who had admitted the majority of low back pain patients before 1985, to ask how care had changed and patients were doing. "In some respects, doctors felt people were still getting good medical care, but that patients took a longer time to recover from their injuries, spent more of their time debilitated at home and had trouble with outpatient services," she says.

From this, Dr. Orlowski wonders "whether we have done something good or bad." She asserts that the PRO was "very smart" to look at DRG 243. "It's a soft diagnosis. People do not drop dead of low back pain."

The Illinois Hospital Association's Chris Bailey thinks, however, the PRO should further sharpen its interventions and review activities, "more on particular cases and diseases that they think are not being appropriately treated, or on particular institutions or physicians they believe are having difficulties." He terms the PRO's utilization review system now as "scattershot, [which is] the design of the system HCFA developed."

Since its inception, the PRO has intensified its review on providers "with unusual denial rates, viewed by diagnosis-related groups (DRGs) or medical diagnostic categories (MDCs)," according to Steve Kaufman, the PRO's chief operating officer for review services. This has produced "positive results," he says. The PRO is currently refining its analysis even further, "as well as working to educate doctors and hospitals with specific information on DRG and MDC denial rates," Kaufman adds, "to assist them in providing quality care in the most economical way." ▲

(continued from page 8)

health care climate, and everyone has a good reason to be unhappy," says IHA's Chris Bailey. "Hospital administrators don't want to be put in the box of having an economic incentive to lower the length of stay. That economic incentive is sometimes opposite the individual patient's [best interest]."

According to Bailey, these confrontational incentives have forced hospitals to set up fairly elaborate systems to protect patients from the "economic incentives overpowering the treatment."

Despite such protections, Dr. Brown admits MDs are definitely getting more pressure these days from their hospitals. Physicians are caught in the middle, "getting pressure from patients who want to stay in the hospital and from hospitals who want to move them out." He says he knows of hospitals posting lists of MDs with a certain number of payment denials. And he wouldn't be surprised "to see hospitals not wanting to sign on a physician with a high denial rate."

. . . MDs must not bow to hospital pressure. . . . "Doctors should err on the side of safety. We shouldn't have any doubts when we send a patient home."

But Dr. Kiessel warns that MDs must not bow to hospital pressure. "It's not going to be pleasant all the time," he says. "Doctors should err on the side of safety. We shouldn't have any doubts when we send a patient home," stressing that "it's a lot different when you're responsible to care for a patient than when you're reviewing care at a later date without that responsibility."

Drs. Brown and Orlowski, and the PRO's Kaufman concur that hospitals will likely not remain the only losers when the PRO denies payment for inappropriate utilization of care in the future. "Its always been thought [by HCFA] that physicians should be liable in some monetary way or otherwise penalized for utilization decisions," surmises Dr. Brown. Medicare's fiscal arm is now beginning to link hospital denials with attending MD charges, echoes Kreie.

What the future holds

Opinions vary on how aggressive the PRO actually is in citing and upholding utilization review denials. While Kaufman says the Illinois PRO's denial rate exceeds the national average, he cites continuing evaluations from the federal government's "super PRO" to beef up the denial rate even further.

Despite these pressures, most acknowledge that CCMFC has been even-handed in implementing an unpopular and often confusing set of Medicare regulations.

"Many doctors who complain about PRO activities don't realize the PRO must closely follow federal law and regulations. CCFMC appears to be doing the best it can to administer an extremely onerous law," says Donald Rokosch, M.D., ISMS council on economics chairman. The group represents ISMS concerns to the PRO. He adds that the PRO has been receptive to physician input on all the criteria, and cites ISMS recommendations on preadmission requirements for 10 elective procedures as the most recent example.

Dr. Orlowski seconds the view that "They're willing to work with us. I have found them to be responsive."

The PRO's utilization role is steadily expanding, says Kreie, with review of ambulatory care and the military's CHAMPUS program now underway.

Is Medicare recouping its cost nationwide on this complex and intensive utilization review process? Is it worth the effort? "They've been close to the vest on that data," says Dr. Brown. "But physicians close to the national level have suggested that the process may not be paying for itself. The cost of the bureaucracy may actually be exceeding the cost savings it was intended to create." Others, however, dispute that arithmetic, and emphasize the utilization review program aims at more than mere monetary savings: assuring appropriate utilization and quality of care to Medicare beneficiaries.

Nonetheless, says Dr. Rokosch, "In a capitalist society, the people who pay the bill have determined they have a right to know how and why they're spending their money." That means, he believes, that utilization review is probably here to stay. ▲

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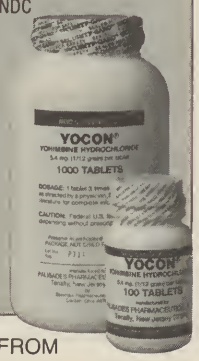
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But sadly enough, the problem plaguing "hospitals nationwide," according to Robert Arrol, M.D., a family practitioner at Jarman, "of being squeezed out by financial troubles," has finally touched base in this Illinois "heartland."

The issue is hardly a simple one for Douglas County residents, and it has put the community into uproar. Many of the headlines of the town's newspaper, *The Tuscola Review*, have been dominated by the issue. So has the talk around town, and rightly so. In November, the county's 10,000 registered voters will answer yes or no to the referendum question, "Shall Douglas County levy an annual tax of not to exceed 25 percent per $100 of assessed valuation for the purpose of maintaining public nonsectarian hospitals?"

Cash flow problem

Since 1957, as far back as the hospital's records go, Jarman's operating expenses have exceeded its revenue. Only in the last three years has the situation reversed itself to where revenues exceeded expenses, and then only marginally. The hospital has maintained solvency throughout its history mainly through cash contributions from the county (contributed directly into its cash receivables fund), according to Mark Fedyk, Jarman's hospital administrator. Each year the county board kicks in about 15 percent of the hospital's operating expenses, which "has been sufficient to offset the losses in revenues," said Fedyk.

For example, in 1979, the hospital had $2 million worth of expenses, of which 15 percent was offset by the county. Meanwhile, the hospital's revenues for 1979 totaled $1.9 million. "Fifteen percent of $2 million versus the revenue of $1.9 million, you can see there would be a cash flow situation that your accounts receivables can offset," said Fedyk.

Skyrocketing contractual adjustments

However, the hospital's financial problem, according to Fedyk, is due to "skyrocketing contractual adjustments, also known as revenue deductions or uncompensated care, the difference in what Medicare/Medicaid pays versus our charges." From 1957 to 1984, the hospital's average revenue deductions of the total patient revenue were 2.6 percent. From 1985 to 1988, Jarman's revenue deductions averaged 18.3 percent.

"If you add up all the contractual adjustments from 1957 through 1988, 86 percent of that total has occurred within the last four years." Fedyk adds. "Because the contractual adjustments have gone up so high within the last year, we've needed extra monies from the county general fund, forcing the county board to look for an alternate source they can levy for separately," he says.

County board member Alan Michener says the dilemma has been slowly mounting over the years. "Everybody knew that every month, it was a hand to mouth situation. When we received notification from Medicare that our reimbursement would be cut by about 20 percent, it was the straw that broke the camel's back. The hospital came to us for help, but we don't have that kind of money in our reserves," said Michener.

Most of Jarman's patients are Medicare/Medicaid, according to Dr. Arrol. "We lose money every time a patient is admitted, coupled with the fact that we don't have most of the beds filled."

Lack of physician utilization

Keeping the hospital's beds filled is another, related problem. "Because reimbursement rates are lower, Jarman must make up the money in patient volume," according to Fedyk. However, county board and hospital officials claim the second problem is lack of physician utilization of the hospital. "Of 58 beds in Jarman, its daily inpatient occupancy rate is only four or five individuals," said Dr. Arrol.

Of 58 beds in Jarman, its daily inpatient occupancy rate is only four or five . . .

Only five of the seven physicians in Douglas County utilize the hospital and some say the doctors there are to blame for the under-utilization. "If local doctors use the hospital, we wouldn't have any problem. But doctors from Tuscola don't send patients here. Instead, they send them to Champaign or elsewhere," said Ramon Climaco, M.D., of Arcola, situated about eight miles outside of Tuscola. "If the hospital closes, I have no other choice but to drive 18 miles to Sarah Bush Lincoln Health Center, when this hospital is convenient for me and my patients," he said.

Arun Bajaj, M.D., who has been practicing in Tuscola for 10 years, says he won't be affected if the hospital closes. "I admit ninety-five percent of my practice to Sarah Bush Lincoln Health Center in Mattoon. But this community needs a hospital and I have no complaints as far as medical care goes for the five percent of my patients I admit to Douglas Jarman," Dr. Bajaj said.

The hospital's downfall in utilization, according to Dr. Climaco, began when Lewis Akins, M.D., a former physician at Jarman Hospital, retired. "When Dr. Akins retired this year, we saw a 30 to 40 percent drop in patient admissions." He says, "My contention is, you don't have to vote for or against the referendum, all you have to do is tell your doctor you want to be admitted to Jarman. It's as simple as that, just a matter of utilization."

Liability and convenience

Fedyk cites liability and convenience as reasons why the hospital's physicians refer patients to Champaign. "A lot of patients with a simple pneumonia are referred out of this county to another hospital, when it could have been treated here. But they [physicians] didn't want to treat it." When doctors refer patients to other doctors, they don't have to worry, he said. "They don't have to mess with discharge and admitting procedures. All they do is see patients in a nice little office practice and refer them on. Although physicians are not 100 percent of the problem, their practice patterns need to change."

Better medicine, increased technology

"You have to blame physicians because they're the only ones who can admit," Dr. Arrol acknowledges. "Yet at the same time, in my case, I refer on. However, liability is not the problem," he says. "It's a matter of better medicine.

"I've been in the business for 24 years and times have changed. We don't have specialty care here available 24 hours a day."

"It's a real dilemma," says Dr. Arrol. "I don't want to see it close, but I'm also a citizen of Douglas County, a taxpayer, and you can't keep paying taxes for something that takes too much money. I understand when people say 'this is too much money,' but I don't know what the real solution is."

Board members comment

When asked what will happen if the people vote no to higher taxes, the seven Douglas County board members said they "didn't know" either. "When I asked the board that same question yesterday, they sure didn't answer me. I've been on the board for 10 years and I've always said I didn't get all the information. I don't know where she'd [Douglas Jarman] go without that help," says county board member Warren Arthur, who voted against the referendum.

County board members initially rejected the referendum, 4-3, in a previous session.

Arthur voted in favor the first time around. "I thought we needed to give the people a chance to say how they felt about the tax they're paying to the hospital. The next week, a lot of my constituents told me they did not favor the referendum. They said they wanted the hospital, but they didn't think the referendum would save it. I would favor the hospital 100 percent if we were filling it to a two-thirds or three-quarter capacity, but I don't think the tax is going to be enough money to keep the hospital going," says Arthur.

"Personally, I feel that the burden is lifted and somewhat put on the taxpayers," says Michener, who has "been fighting this thing for seven years."

"But," he adds, "I am one of the two county board members who reside in Tuscola. Consequently this referendum is much more important to us."

County board member Russell Ghere favored the resolution. "But I'm about ready to change my mind," he now says. "I want the hospital to stay open, but the hospital is getting just a bit too much money from our county budget."

Farmers opposed

The tax is expected to generate about $400,000 and will cost about $50 a year for a homeowner of a $60,000 house. If the tax passes, farmers can expect to pay about 85 cents per acre, according to Virgil Luth, county board chairman.

Michener says farmers are especially opposed to the tax. "The farm population is affected very differently from this. The farmers have a whole lot more land to pay [tax on]."

Critics of the referendum are very skeptical of its passage. Douglas County residents were hit with a school referendum they favored several months ago. Meanwhile, Michener said Jarman will have to go into debt until the referendum passes because it has no reserves to pay off current bills.

Jarman will need about $20,000 a month for the rest of the fiscal year that ends in December to pay its bills. The county may have to borrow money from banks or from other county funds that will eventually have to be paid back to foot the bills, said Michener.

Michener called the referendum a long term solution to an immediate problem. "More money is strictly a bandage solution until they can do something in regard to utilization. That only comes through recruitment of physicians or existing physicians using the facility more."

Dr. Climaco agrees, "How can you recruit doctors when there is no future security for the hospital? I wouldn't go to a place where there is no hospital."

Solutions proposed

Fedyk said he has been making efforts to recruit physicians to Douglas County. "I'm not waiting for a referendum to decide the course of action here," he says. "We have two interviews scheduled this weekend and we interviewed three candidates within the last couple of months."

"I don't think it's an all or nothing proposition, or it shouldn't be," says Dr. Arrol. "I think the hospital needs to look at each area, the outpatient, the third floor inpatient, the emergency room, the lab and see which departments are making or losing money, and then say this is how much money we have, this is what we can keep open."

Several county board members suggested a clinic type of setting as an alternative. However, "According to the financial comparisons we've done, it would actually cost more to run this as an outpatient facility than it would as both an inpatient/outpatient facility," said Fedyk, "because we'd still have to have housekeeping, a business office, medical records and there would be no place to spread these costs. So the answer is not more outpatient procedures, but more utilization on the inpatient side," he says.

The hospital currently has an emergency room, x-ray department, laboratory, physical and respirator therapy, and it leases space to a mental health facility located in the building.

County officials say closing Jarman will also require money. "You're going to have closing costs and contracts that someone is going to have to pay to get out of. If you don't keep someone in that building, it will be junk in six months to a year," says Jack Allen, the Douglas County clerk.

Indigent and elderly mostly affected

According to Fedyk, the indigent and elderly will be most affected if the hospital closes, because of accessibility. Douglas County has no public transportation and residents would be forced to travel to Champaign, Decatur or Mattoon, anywhere from 25 to 45 miles away.

"Unfortunately, our little hospital is caught in the squeeze with several big hospitals to the north, 23 miles away. To the south, there's another big hospital 25 or 30 miles away. It's the way the times are," says Dr. Arrol. ▲

Evaluating the risk of Lyme disease: a new concern

by Bernard J. Turnock, M.D.,
Director, Illinois Department of Public Health

LYME DISEASE (LD) appears to have taken hold in limited areas of Illinois, probably as a result of spread from the known endemic focus in Wisconsin. During the first nine months of 1989, 55 cases of LD that meet clinical, epidemiological and serological criteria have been diagnosed in Illinois residents. About half of LD cases in Illinois report exposure within the state, most predominantly in northwestern counties where the deer tick (*Ixodes dammini*) has been identified. A few indigenous cases report exposure in central and southern counties, suggesting the LD risk in these areas is probably low.

Even though LD appears most commonly in the summer, there is need to consider LD in the autumn as well. During the autumn months adult ticks are seeking their last blood meals before spring. The autumn LD risk declines with the onset of winter, but may continue at a low level if warm weather permits continued feeding by adult female ticks. Hunters remain at risk throughout autumn.

When patients present with symptoms suggesting LD, they should be evaluated clinically, epidemiologically and serologically. The use of antibody tests has become common practice in evaluating patients for LD. These tests are available from numerous private laboratories, as well as from the Illinois Department of Public Health (IDPH) laboratory. The following are important considerations regarding the use of LD antibody tests:

- LD serologic tests are of maximum diagnostic benefit when evaluated in the context of the patient's clinical and epidemiologic history. They should not be the sole basis for establishing a diagnosis or for antibiotic therapy.
- LD antibodies tend to rise slowly after onset of initial symptoms. Testing within the first four weeks after onset of early LD is usually nonproductive. If the patient has: (1) suggestive signs and symptoms of early LD (e.g., erythema migrans accompanied by influenza-like symptoms); (2) exposure in an area likely or known to be inhabited by deer ticks; and (3) a negative antibody titer within the first four weeks after onset, re-testing the patient eight weeks later (twelve weeks after onset of symptoms) may prove useful to serologically confirm the diagnosis.
- Serology can be more useful when evaluating patients in the later LD stages. After ruling out more common causes for patients' symptoms, LD serology should be considered. Antibodies are usually present, leading to diagnosis.
- While comparison of acute and convalescent phase sera is useful for confirming the diagnosis of many infectious diseases, it is seldom indicated in LD. However, paired sera may be useful when attempting to establish a diagnosis in early cases reporting exposure in endemic areas and for those who present with mild or vague constitutional symptoms without erythema migrans.
- Appropriate antibiotic treatment early in the clinical course may interfere with the antibody response. Re-testing treated patients who fail to develop antibodies at a later date may be indicated if laboratory confirmation of the clinical diagnosis is desired.
- Monitoring antibody levels is generally not useful in evaluating successful treatment because antibodies do not always decline after treatment.



Photo: Ron Ackerman

Bernard J. Turnock, M.D.

- Serologic testing of persons with tick bite in the absence of symptoms is probably not useful. Following these patients for the development of signs or symptoms, evaluating them clinically, and testing for LD antibodies following an appropriate interval after onset is, however, appropriate.
- Other spirochetal infections (syphilis, leptospirosis, *Treponema microdentium*, etc.), infectious mononucleosis and autoimmune disease cause false-positive LD antibody results.

Serologic confirmation of LD may become more consistently reliable in the future as researchers continue to refine the specificity of existing test methods. Clearly, Lyme disease is establishing a foothold in Illinois, and practicing physicians must be alert to its presence in patients. ▲



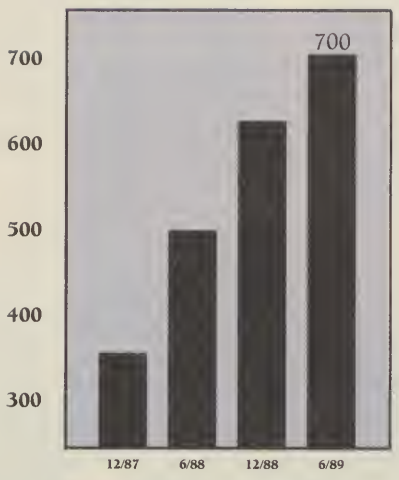
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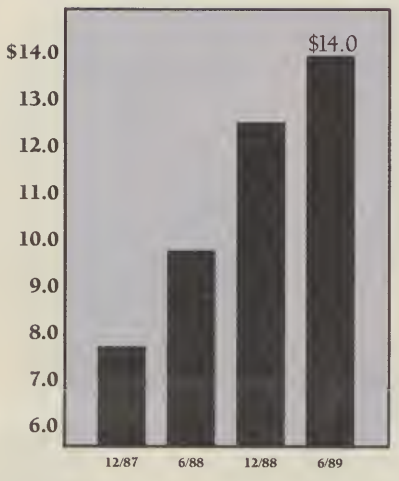
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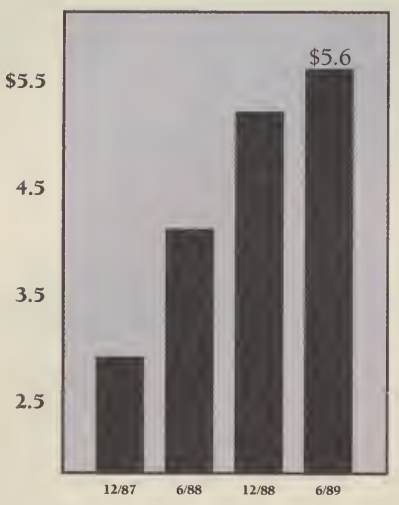
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Helmet removal: it's how you play the game

IT'S A NOT-UNUSUAL situation in school and professional sports: a player is injured during a football game. He is carried off the field in obvious pain or even unconscious, and set down on the sidelines. Emergency medical technicians suspect a cervical spine injury and want to immediately remove the helmet to examine the head, face and neck area or provide CPR. Should the helmet be removed?

Absolutely not until "thorough evaluation eliminates the likelihood of a potential cervical spine injury," say the new guidelines for acceptable methods of helmet fitting and removal in athletics recommended by the Illinois State Medical Society (ISMS) committee on sports medicine.

According to the report, recently approved by the ISMS board of trustees, "The jostling and pulling required for removal has a high potential for causing further trauma and can be life-threatening."

Serious injuries possible

"The most serious injury may occur when there's been a spinal injury, because of the potential for total paralysis," says Merle Muller, M.D., team physician for Fairfield Community High School in Wayne County and a member of the committee. Dr. Muller encountered the previous football scenario last year. "I had one player in whom we suspected cervical spine injury. At the time, we were at another community and the emergency medical technicians (EMTs) wanted to remove the helmet right away. I had to convince them that was not the proper route to go."

"The committee's recommendation stemmed from concern for potential misunderstandings that have occurred in the past between physicians and emergency medical personnel present at games where accidents often occur," says Preston Wolin, M.D., team physician for Loyola University and St. Rita High School and team orthopedic surgeon for De Paul University. Dr. Wolin is also a member of the ISMS sports medicine committee.

"The question of who's directing care at some sporting events has become an increasing problem, more so in larger communities where a number of individuals such as trainers, EMTs and physicians cover games," says Dr. Wolin. "Because of this, the patient may get the short end of the deal.

"Most emergency medical professionals have been trained to remove helmets to better examine the head, face and neck area. This is something that's grown out of motor vehicle accidents," says Dr. Wolin. "However, in the case of football injuries, it has been well documented that a complete examination can be done without removing the helmet. In addition, it's safer to immobilize the patient by leaving the helmet on between the time the patient leaves the field and arrives at a medical facility."

Examining the helmet-bound patient

The committee maintains in its report, "While the football helmet mask is certainly an impediment to standard evaluation techniques, *it is possible* to look, listen and feel for breathing through the face mask."

Dr. Wolin outlines guidelines for acceptable ways to proceed on the field with an injured player. If the patient is lying face up, physicians should examine the airway, face and head to inspect for any possible breathing problems or visualization of any lacerations about the face. At the same time, a neurological exam should be performed to evaluate the status of the upper and lower extremities. The neck should be felt for any tenderness, specifically tenderness about the bones. These procedures should be completed while keeping longitude traction on the neck, stabilizing the neck while the procedures are done.

If more direct access is needed to the face, the face mask, not the helmet, can be removed through a number of different procedures. The quickest way is to cut the fasteners attached to the mask with bolt cutters, a pen knife or scalpel blade. Individuals providing on-field coverage should keep these instruments handy at all times while monitoring a game, according to the committee. The newer face mask models may be removed with a simple screwdriver.

"All new helmet models are being manufactured to operate so that you can cut through the plastic, remove the face piece without too much trouble and still maintain the helmet itself to control the head," says Dr. Muller.

If the patient is face down, according to Dr. Wolin, the physician should also perform a neurological evaluation by rolling the patient on his back onto a spine board with proper assistance, using at least three people. The physician should maintain longitudinal traction of the neck while the other two individuals roll the patient. If there is no physician present, a certified athletic trainer is well-trained on how to control traction of the neck, says Dr. Wolin.

Dr. Wolin adds that "the physician should feel no pressure to perform the procedures in a hasty fashion. Most officials and coaches have been schooled to render as much time as necessary to ensure appropriate care is given to an injured player."

Once the patient is on the spine board, his helmet, and therefore his neck should be secured by taping two sandbags onto the spine board on either side of the helmet. In addition to preventing the neck from moving, the sandbags will deter the risk of removing the helmet, says Dr. Wolin. The patient is now ready to be transported to the emergency medical facility in a stable position where physicians can administer a lateral x-ray immediately upon arrival. Satisfactory cervical x-rays can be obtained with the helmet in place, according to the committee. "Once the lateral x-ray is taken, if there is no pathology seen," says Dr. Wolin, "then it's probably safe to remove the helmet."

The committee stresses that because of a very high rate of accidents in football, its guidelines focus on football helmet removal. The recommendations, however, should be applied to other sports such as lacrosse and hockey, where tight fitting helmets are also worn.

Team doctors needed

The committee encourages physicians to get involved with school teams. "There are plenty of opportunities at the local level because so many schools are without team physicians," says Dr. Wolin. Interested physicians can obtain reading and educational information about being a team physician from the ISMS sports medicine committee. "As team physicians, they often times can get involved in the planning of conditioning programs for the high schools, have input into the care and rehabilitation of injured players, interact with the coaches and give medical advice to the parent's association on what sports medicine can do to improve high school athletics," he says. ▲

Doctor's Fair

(continued from page 2)

none of them close to retirement.

John Record, fair organizer for SIU, also isn't optimistic about the chances of cities such as DuQuoin and Mattoon to attract physicians. Very small communities have just about given up trying to recruit doctors, he said.

Record said there was agreement among those communities which responded to his survey that improvement of their local economies would maximize their chances of attracting physicians. He says doctors choose communities much as industry chooses new sites for factories. The slow, sometimes depressed, economies of smaller downstate communities can severely impair recruitment.

"If you don't have a sound economic base, there is a ripple effect on many areas physicians consider, such as condition of local schools and hospitals and the availability of employment opportunities for spouses," said Record.

Smaller communities and the rural areas around them are becoming a less and less important part of the Illinois population, Record said. According to census figures, in 1987, 83 percent of the state's residents lived in the large metropolitan areas of Chicago, Rockford, Peoria, Champaign-Urbana, or Springfield.

Malpractice insurance reform and improvement of Medicaid payments to doctors and hospitals also ranked high on the communities' lists of problems to be solved.

But small size isn't the only indication that a community will have difficulty in recruiting doctors. Decatur, a central Illinois city of more than 90,000, has a physician shortage, too. An industrial city, Decatur lost jobs in the 1980s through layoffs and plant closings.

"We have really seen an upswing in the economy," says David Smith, a representative of St. Mary's Hospital, Decatur at the doctors fair. But Decatur still suffers from a shortage. Obstetrics, internal medicine, pediatrics and family practice were all on the Decatur shopping list at the fair, as were plastic surgery and psychiatry. ▲

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(continued from page 1)

been reached, hasn't been allowed in Illinois." Doctors, she added, already do their best to determine fetal age.

Other legislators took a pragmatic view. "I'm not offended by [the pro-life forces trying to push their proposal at this time]," said Rep. John Cullerton (D-Chicago). "In light of the Webster case, legislators are examining their abortion stances, and some are changing them."

Asked about the chances for this bill's passage from committee, Cullerton noted that the one absence at the October 17 vote was Rep. Terry A. Steczo (D-Oak Forest), who voted against H.B. 574 in May.

Doctors testify on fetal viability

Testimony on the merits of H.B. 574 took place before a House-Senate conference committee October 10, and centered fetal viability testing.

"Using a cutoff date of 20 weeks is farcical," testified Marvin Rosner, M.D., an assistant professor of clinical obstetrics/gynecology at Northwestern University. "At 20 weeks a fetus would weigh less than 14 ounces, not enough to survive."

The testing requirement itself seems "very reasonable from a clinical point of view," said Robert Kaufman, M.D., a maternal/fetal medicine specialist at the Southern Illinois University School of Medicine. But he, too, challenged the time frames involved in the bill, questioning whether fetal development can be precisely known in many cases. Dr. Kaufman said the margin of difference between perceived and actual gestational age is often great—sometimes more than four weeks.

Fetal tissue research

In related news, the House overrode October 18 Governor James R. Thompson's amendatory veto of H.B. 2693, which would have prohibited the use of fetuses, fetal organs or tissue obtained in abortions, in any kind of animal or human research, experimentation or transplant. Thompson had opposed the bill, saying that fetal tissue has been valuable in research and medicine. ISMS had also opposed the legislation, saying that, ". . . if overridden, [the bill] would halt vital medical research," and that "the decision to have an abortion must remain separate from the decision to donate the postmortem tissue." ▲

M.D.s fault abortion regs

by Kevin O'Brien

Four prominent Chicago obstetricians took the highly unusual step of calling a press conference October 19 to criticize the Illinois regulations governing abortion clinics.

"In my personal opinion, this entire effort by the state is a sham to restrict abortion," said Arthur Herbst, M.D., chairman of the University of Chicago department of obstetrics/gynecology. Joining Dr. Herbst were Melvin Gerbie, M.D., professor of clinical obstetrics at the Northwestern University Medical School; Marilyn Fredericksen, M.D., assistant professor of obstetrics/gynecology at Northwestern; and George Wilbanks, M.D., chairman of the Rush-Presbyterian-St. Luke's department of obstetrics/gynecology.

The physicians specifically criticized provisions of the Illinois Medical Practice Act that preclude doctors from performing first trimester abortions in their offices, and regulations of the Ambulatory Surgical Treatment Center Act that require abortions be performed in clinics equipped like hospitals.

They expressed support for an *amicus* brief filed Oct. 14 with the U.S. Supreme Court by the American College of Obstetricians and Gynecologists (ACOG) in support of Rockford physician Richard M. Ragsdale, M.D. In *Turnock v. Ragsdale*, Dr. Ragsdale contends that complying with the regulations would be prohibitively expensive for most clinics, resulting in their closure, or higher fees placing abortion beyond the reach of poorer women.

The physicians said that safe first trimester abortions depend not on the clinical setting, but on gestational maturity, the procedure employed and the physician's skill. "ACOG's standards explicitly state that abortions up to 14 weeks may be performed safely in physicians' offices and clinics, provided they are properly staffed and equipped," said Dr. Herbst.

On Oct. 16, Illinois Atty. Gen. Neil F. Hartigan convened the parties in the Ragsdale case to discuss a possible settlement before it is heard by the Supreme Court on Dec. 5. No agreement was reached, but both sides said they would meet again Oct. 25. ▲

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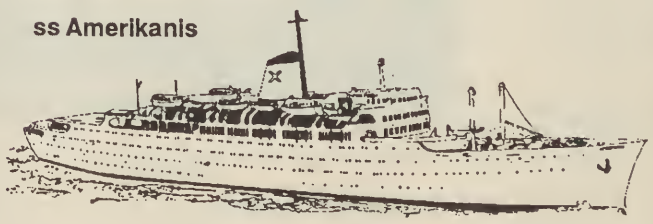
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Illinois Medicine

November 10, 1989

ILLINOIS STATE MEDICAL SOCIETY

Rural health bills meet mixed destinies at legislature's close

A VARIETY OF BILLS seeking to improve rural health care services in Illinois met varied fates as the Illinois General Assembly concluded its fall session November 2.

A total of eight bills passed by the General Assembly during the spring session returned for legislative debate this fall, after they were vetoed by Governor James R. Thompson. The governor, who was supportive of the legislation in principle, had vetoed the bills because of lack of funding by the General Assembly.

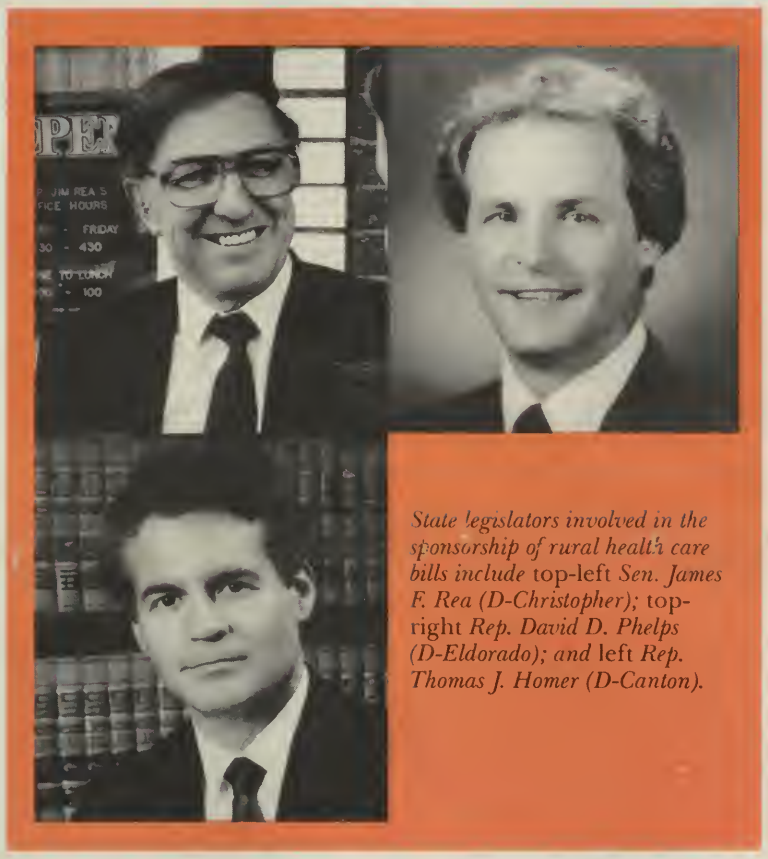
When the veto session ended November 2, three had become law, while four were defeated, and two awaited action by Gov. Thompson.

Malpractice reimbursements killed

One bill which went down in defeat, S.B. 1303, would have authorized the Illinois Department of Public Health (IDPH) to award grants for reimbursement of malpractice insurance premiums for family practice and obstetrical physicians who practice in underserved areas. The reimbursement would not have exceeded 50 percent of the premium. S.B. 1303 was sponsored by Representative Larry Woolard (D-Marion) and by Senators James F. Rea (D-Christopher), William O'Daniel (D-Mt. Vernon), and Vincent Demuzio (D-Carlinville).

The three bills passed into law (including

(continued on page 14)



State legislators involved in the sponsorship of rural health care bills include top-left *Sen. James F. Rea (D-Christopher);* top-right *Rep. David D. Phelps (D-Eldorado); and* left *Rep. Thomas J. Homer (D-Canton).*

AMA official resigns; board investigates fund transfer

THE BOARD of the American Medical Association (AMA) held an emergency meeting Thursday, November 2, in the wake of disclosures that a top AMA staff executive admitted receiving an "inappropriate" $353,000 payback of personal pension assets he had lost in the October, 1987 stock market crash. Whalen Strobhar, president of American Medical Services, Inc., the AMA's holding company for its for-profit subsidiaries, resigned October 26, and will repay the funds plus interest, according to an October 27 AMA statement.

Strobhar's resignation came after inquiries by the Chicago *Sun Times*, and just prior to publication of an October 29 front page story. Strobhar had worked at AMA for 25 years. At the time of the funds transfer, he served as the organization's chief operating officer.

(continued on page 2)

Lutheran General/Grant talks collapse

by Kevin O'Brien

NEGOTIATIONS leading to the consolidation of operations of two near north side hospitals have collapsed, resulting in a Lutheran General Health Care System decision either to sell or close its Lincoln Park facility, *Illinois Medicine* learned November 1.

For several weeks, officials of Lutheran General and Grant Hospital of Chicago have been negotiating a possible consolidation of operations of the 300-bed Lutheran General Lincoln Park Hospital (LGH-LP) at 2035 N. Lincoln, and the 500-bed Grant two blocks away. Lutheran General's main hospital is a 700-bed facility in Park Ridge.

Last month, Lutheran General and Grant jointly hired John Nuveen & Co. to study options for the proposed consolidation. However, in a Nov. 1 memo to the LGH-LP staff, Lutheran General said that "Although the [Nuveen] study concluded that the merger would be in the interests of both parties, the [hospitals'] Boards were unable to reach agreement. Accordingly, the merger talks were terminated today."

"The Boards of the two hospitals were not able to resolve various management issues, as well as what would happen to the Lincoln Park facility," said Lutheran General spokesperson Cathy Barry-Ipema.

A spokesperson for Grant Hospital confirmed the cessation of talks, but said officials would have no further comment at this time.

The staff memo said that Lutheran General now had two options: either sale of the hospital to another health care organization, or " . . . reluctantly, closure of the hospital." Barry-Ipema said that two groups have recently expressed interest in buying the facility, formerly Augustana Hospital. While declining to identify the potential buyers, she said that one was a group of area physicians which was "very interested."

LGH-LP employees were told that both options would be under intensive review over the next two months, but that "these events are fast-moving and a decision and an announcement could be made during the month of November." Employees were advised that they would receive a minimum 60-day notice if the hospital is closed. ▲





Wm. Daniels/The Photo Partners

Consolidation talks have broken down between Lutheran General Hospital (left) and Grant Hospital of Chicago.

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No elective abortions at new Covenant Medical Center

Champaign hospitals merger now complete

by Janice Rosenberg



Champaign's Burnham (L) and Urbana's Mercy Hospitals have merged.

ON OCTOBER 2, two of Champaign-Urbana's major hospitals, Champaign's Burnham and Urbana's Mercy, officially merged, ending several years of negotiations. The new institution, Covenant Medical Center, is owned and operated by ServantCor, a not-for-profit corporation established in 1984 by the Holy Heart of Mary Sisters, the Roman Catholic order that has owned and operated Mercy Hospital throughout its history. Burnham Hospital was owned by the City of Champaign before the merger. The fact that a Catholic and a public hospital were merging provided the main source of contention between negotiating teams during the talks.

A major sticking point in negotiations was the availability of abortion and other reproductive services. Mercy had never allowed abortions except to save the life of the mother, while Burnham had been a major site for reproductive services, especially for poor women.

In the end, the negotiators agreed that the new hospital would not perform abortions except to save the life of the mother. "We do follow the ethical-religious guidelines of the Roman Catholic Church, which means basically no elective abortions or sterilizations will be done at either facility," said Stuart Fulks, ServantCor's vice-president of marketing.

In accordance with the master consolidation agreement, the CEOs of both organizations were required to give up their positions. A new board has been named for Covenant which draws its membership from a cross-section of constituencies. Board member Ronald Deering, M.D., medical director of the Christie Clinic, doesn't anticipate any major difficulties resulting from the merger. "We're hopeful that the history plus the common goals that we have in improving the non-Carle hospital situation will allow us to cooperate well with one another in the future," he said.

In recent years, neither Burnham nor Mercy had been operating at more than a 60 percent occupancy rate, suggesting that the community could not support three hospitals. "We can support two different individual health care delivery systems," said board member Everette C. "Clif" Burdette, Ph.D., president of Labthermics Technology. "In that sense we may now have the best arrangement with a strong but equal competitive situation. I think that's good for the community."

Not everyone is happy about the merger. Robert Brunner, M.D., who led independent physicians in fighting the merger, did not wish to comment on the final results. He is not a member of the new board. The independents wanted to keep Burnham separate, fearing the merger would lead to an eventual shutdown of their hospital.

Champaign mayor Dannel McCollum said the issue of how to use the two facilities will be decided by the new board. "I think that Burnham will cease to be a center for acute medical care," he said recently. "If there is a market for step-down care, it could be converted."

Fulks, too, sees the question of consolidation of clinical programs as a matter for the new board. "ServantCor can't automatically say 'this is the way things are going to happen'," but, he added, "It doesn't make sense to do open heart surgery at both locations." Fulks predicts "lots of pressure on the board from all directions."

Board member Stanley Bobowski, M.D., head of pathology at Burnham, sided with the independent physicians. He views the merger as leading directly toward the gradual closing of Burnham. "The independent physicians are afraid that when it closes there won't be enough beds," he said.

Obstetrics is the only department to have left the Burnham "campus" for Mercy. A new intensive care unit is being built at Mercy.

"There is no reason to think that in the current merger we'll be talking about any layoffs," said Fulks. Mayor McCollum agreed. A high level of turnover at the two facilities results in a natural attrition rate for hospital employees of about 25 percent annually, he said.

As for employment figures in the community as a whole, McCollum sees a potential short-term drop. "I think you would have to back that up against the strong probability that one of the hospitals might have collapsed anyway and the other wasn't in any great shape," he noted. "Because of the changes in hospital economics, changes were inevitable. This way we'll have long-term protection." ▲

ASTCs receive new state regulations in November

by Kevin O'Brien

THE NUMBER OF state-licensed Ambulatory Surgical Treatment Centers (ASTCs) is expected to increase by at least between 21-32 percent as a result of new regulations that redefine ASTCs.

The regulations, made effective November 1 by the Illinois Department of Public Health (IDPH), are actually amendments to existing regulations. They are intended to create a "level playing field" in the state's ASTC industry, said Illinois Department of Public Health (IDPH) spokesman John R. Lumpkin, M.D.

"The intent of the amendments is to clarify the definition of an ambulatory surgery treatment center [in order] to treat all centers in a fair fashion," said Dr. Lumpkin.

Dr. Lumpkin noted that 10-15 additional Centers are expected to seek

(continued on page 13)

Physician Facts

The Great American Smokeout Kicks Off Again

The Great American Smokeout, the American Cancer Society's (ACS) annual one-day focus on smoking, is scheduled for Thursday, November 16. The ACS is once again promoting a wide variety of activities to raise awareness on the dangers of smoking and to encourage American smokers to quit.

For further information, call (800) ACS-2345.



Source of Data: Illinois Department of Public Health, Feb. 1989

AMA

(continued from page 1)

At its November 2 meeting, AMA board members received "an interim report on the investigation" being conducted by Jenner and Block, Chicago, special legal counsel hired by the board, according to a statement released after the meeting.

"Upon completion of the investigation the Board will take appropriate organizational action which it is confident will strengthen the Association," the statement said, and that top AMA staff are "cooperating" and "fully supportive."

AMA Executive Vice President James M. Sammons, M.D. two years ago approved the pension fund repayment to Strobhar and reversed that decision last week. He said, "Mr. Strobhar stated it was not his intention to transfer his funds from fixed instrument investments to the stock market. Although he had completed and signed an authorization form calling for such a transfer, he stated that he did not intend for the form to be submitted."

The form was, however, processed just prior to the October 1987 stock market crash, and Dr. Sammons said he subsequently "granted Mr. Strobhar's request to reimburse him for his stock market losses," based on "what I perceived at the time to be an error on the AMA's part."

Strobhar was reimbursed for his pension losses from AMA reserves, comprised of publication revenues, member dues and other monies.

Dr. Sammons said that a later internal investigation "revealed inconsistencies" in Strobhar's pension fund transfer. "There are certain facts surrounding this transfer that cannot be corroborated by Mr. Strobhar or the AMA," Dr. Sammons said. "Chief among them is exactly how Mr. Strobhar's authorization form was submitted." Because of this, AMA asked Strobhar to repay the $353,000 plus interest.

"AMA members who read of this incident will naturally have many questions," said an October 30 communique from Illinois State Medical Society (ISMS) Chairman Harold L. Jensen, M.D. to ISMS leadership statewide. He added that ISMS is "not aware of any facts beyond the newspaper articles and what AMA has communicated to us. We will keep you apprised of further developments." ▲

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On The Legislative Scene



DURING the October 17-November 2 veto session, state legislators took action on health-related bills Governor James Thompson had vetoed or amendatorily vetoed last spring.

Retirement assets . . . Effective immediately, *all* Illinois citizens' pension assets are protected from creditors in bankruptcy proceedings, including physicians' retirement assets. Gov. Thompson signed this bill (S.B. 162) into law August 30. Thompson vetoed a less beneficial bill (H.B. 247) September 7 that would have excluded from protection the assets of small business persons who "control" more than half of the employer. The governor's total veto on H.B. 247 stands, and the bill is dead; however, S.B. 162 is in full force and effect.

State employees' health plan . . . Physicians and other health care providers who treat patients covered by Quality Health Care Plan, the group health insurance plan covering many state employees, can expect timely payments after a move by the state legislature to approve a $46 million supplemental appropriation to the Illinois Department of Central Management Services (CMS), which coordinates the health plan for 278,000 beneficiaries.

"This is the largest supplemental we've ever received and it puts us in excellent shape to pay our bills in a timely manner throughout the fiscal year, with the possible exception of the last week of June," said Mike Lang, CMS spokesperson. "We had funding approved for 11 months out of the 12 months for each of the last fiscal years, so our deficit at the end of each fiscal year has been carrying over."

The legislature's recent approval is $11 million short of the amount CMS originally requested. "Some of the legislative staff did an analysis and came up with the figure of $46 million to take care of our shortfall. It's hard to predict, but we'll have to wait until June to see if the figure is right," Lang said.

Fetal tissue research . . . The Senate sustained the governor's amendatory veto on H.B. 2693 November 1, two weeks after the House overrode the governor's action, thus defeating the measure. The bill would have prohibited performing an abortion specifically to obtain a fetus, fetal organs or tissue for use in animal or human research or experimentation, or for animal or human transplants. However, the bill also included a provision which would have prohibited the use of all fetal tissue for research or transplantation purposes, unless the tissue was the product of a stillbirth or spontaneous abortion. Thompson amendatorily vetoed that particular provision, because it would unnecessarily have restricted the use of fetal tissue that has been valuable in research and medicine. ISMS supported the governor's amendatory veto.

FDA-approved drugs . . . The House overrode the governor's veto on H.B. 506 October 17, while the lack of any Senate action on the veto killed the bill. H.B. 506 would have required the Illinois Department of Health (IDPH) to include in its definition of experimental treatment the prescribing of an FDA-approved drug for a purpose that may not have been approved by the FDA.

X-ray requirements . . . Both the House and the Senate overrode Thompson's amendatory veto on H.B. 2351. The original bill—now enacted into law—states that physicians may certify the competence of staff members who take x-rays, if such staffers meet prior experience requirements. ISMS supported the original legislation. The bill moves up the sunset clause in the Radiation Protection Act to December 31, 1990, so the entire accreditation procedures for radiologic technologists may be reviewed and rewritten next year.

AIDS . . . H.B. 1876 died after both the House and Senate failed to override Thompson's amendatory veto. The bill would have required individuals seeking treatment at sexually transmissible disease (STD) clinics be tested for HIV. The bill also required DASA to provide HIV testing to its patients being treated for drug abuse, unless the person refused, and the Department of Corrections (DOC) to offer HIV testing to all persons committed 15 days prior to discharge. The legislation included monthly reporting of HIV statistics, including reporting of individuals tested by federal agencies who intend to reside in Illinois. The bill also required the department of Central Management Services to contract with one or more laboratories in the state to provide HIV testing.

Clean Indoor Air Act . . . H.B. 1695, which bans smoking in most Illinois public buildings, passed in the veto session's late hours and awaits Gov. Thompson's signature. However, public buildings such as restaurants, theaters, stores, hospitals and hotels can have designated smoking areas. ISMS supported the legislation. ▲

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(This report is a service to the physicians of Illinois)
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Editorials

ISMIE looks to its history and its future

The Illinois State Medical Inter-Insurance Exchange (ISMIE) is old enough now to look back with wisdom and candor. Sixteen years ago, the company was born of necessity, when it appeared certain that commercial insurance carriers were abandoning Illinois doctors during the malpractice crisis of 1975. In the mid-1980s, a second crisis caused some carriers to cease accepting new physicians, and others to disappear altogether. From the beginning, then, the aim of ISMIE was to save physicians from impending insurance disaster.

Today, ISMIE has been welcoming new policyholders longer than any other medical malpractice carrier in the state. It has outlasted other carriers by making sound decisions and steering a course both prudent and practical. A key element in ISMIE's success has been the realization of the strongly cyclical nature of this unique line of insurance. While 1989 has been a good year for ISMIE, physicians are still being sued, and it is almost certain that new grounds for suing and constitutional challenges to tort reforms will keep the threat of malpractice very real for many physicians.

A mark of ISMIE's increasingly sophisticated approach is the organization's heightened emphasis on preventing suits and reducing losses. ISMIE now offers all policyholders a risk management self-study course that includes video and print collateral and carries six hours of continuing medical education credit. ISMIE also counsels and educates individual policyholders on risk management techniques.

ISMIE's strength lies in its strong commitment to remain an Illinois company serving Illinois physicians, while never forgetting the importance of continued future vigilance. ▲

Elections and health care issues

It's time again for physicians to start thinking politically. Next year is an election year in Illinois, and the races involved are varied and important.

There will be a crucial gubernatorial election, as well as a slate of state legislative and congressional candidates, who will set the stage for health care debates in the 1990s. In addition, the results of those elections will determine the outcome of redistricting. Drawing district boundaries for elected officials often frames how substantive issues are addressed throughout the decade.

With your 1990 ISMS dues payment, please remember the tremendously important work that IMPAC, the Illinois State Medical Society Political Action Committee, is doing on your behalf in Illinois elections. Through your support, the voice of organized medicine can continue to be heard! ▲

Illinois Medicine

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President's Column

Sorry, Mr. Prete, wrong numbers



Eugene P. Johnson, M.D.

Gerald Prete, president of the Illinois State Council of Senior Citizen's Organizations, leveled a variety of accusations against physicians and the Illinois State Medical Society (ISMS) in his July 21 *Illinois Medicine* guest editorial.

Since then, *IM* has received an outpouring of letters from member-readers expressing outrage at Mr. Prete's commentary. Now I would like to set the record straight once and for all on the subjects covered in that piece.

It is unfortunate that the general tone of Mr. Prete's commentary was accusatory. Clearly, he believes doctors practice medicine out of purely financial considerations. In fact, physicians are very concerned about the medical, social and economic welfare of their senior patients. We do not view health care as doctors on one side, senior patients on the other. To the contrary, we believe seniors and doctors want the same thing: continued availability of the best quality health care for senior citizens.

Let's look at a few specific assertions Mr. Prete makes in his guest editorial, and discuss them carefully.

First, Mr. Prete contends Medicare "makes up the largest single source of practice revenue" for doctors, but that the elderly still spend a greater share of their own income on health care than before Medicare began in 1966.

While it's true that Medicare does provide the largest *single* source of MD revenue, these funds are dwarfed in size by combined income from private sector insurers. And while seniors do spend a greater share of their income now on health care, that fact is largely due to tremendous changes in lifestyles, health care benefits and access to care since 1966. As an example, more seniors are going into nursing homes now, whereas many were taken care of by their families 23 years ago.

Second, Mr. Prete states that "excess charges," which he defines as any amount above Medicare's "reasonable" charge for each designated procedure, come directly out of the pockets of the elderly and disabled. He must realize that not all charges are paid; in fact, doctors and hospitals write off a great number of uncollected medical bills, just as businesses write off uncollected charges. When he says that insurance companies will not pay those charges, Mr. Prete is once again incorrect. Some Medigap policies pay up to 120 percent of Medicare-allowable charges.

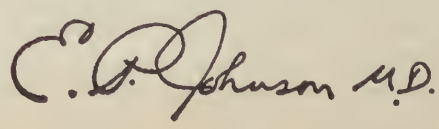
Third, in relation to Medicare assignment, Mr. Prete alleges that the average non-participating physician profits $8,200 a year from "excess charges." The reality is that Medicare's "reasonable" charges are generally *un*reasonably low, so that the annual "$8,200 profit" is hardly that. Rather, the sum represents $8,200 less that must be cost-shifted to patients who are privately insured or pay for health care out of their own pockets.

Medicare requires physicians to give senior patients our lowest charge for every service.

Fourth, Mr. Prete says doctors are threatening to "blackmail" legislators to turn down mandatory assignment legislation, by refusing to treat Medicare patients. Nothing could be further from the truth. The imposition of mandatory assignment would force doctors to choose between accepting assignment for all their Medicare patients, or not treating any Medicare patients. Some physicians—those starting out in practice, those with very high overhead costs, or those with a large percentage of Medicare or Medicaid patients—might find it necessary to limit or entirely give up treating those patients. That is simple, sad economic reality.

Finally, Mr. Prete says that "Congress is rapidly moving to address the changes recommended by the Physician Payment Review Commission." The fact is, Congress is moving on a small number of PPRC recommendations, including limitations on "overpriced" procedures. The resource-based relative value scale (RBRVS) and expenditure targets (ETs) are two additional topics slated to come up for discussion this fall in Congress. These subjects demand a full hearing—particularly ETs, which could have a strong negative impact on access.

It is regrettable that Mr. Prete paints a picture implying that physicians are the enemy to be conquered. We *can* work together, as a society, to ensure the best possible medical care for the greatest number at reasonable cost. But spreading inaccurate information, maligning the medical profession, and creating distrust between the medical profession and patients is not the way to encourage "coming together." ▲



Eugene P. Johnson, M.D.
President

Obituaries

** indicates ISMS member*
*** indicates member of ISMS Fifty Year Club*

Azubalis
Alfonsas Azubalis, M.D., of Fox River Grove, died January 23, 1989 at the age of 77. Dr. Azubalis was a 1936 graduate of Vytauto Didziojo Universiteto Medicos Fakultetas, Kaunas, Lithuania.

***Boeke**
Emmet George Boeke, M.D., of Winslow, died November 9, 1988 at the age of 74. Dr. Boeke was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

****Bolz**
Arthur Norden Bolz, M.D., of Champaign, died February 21, 1989 at the age of 83. Dr. Bolz was a 1932 graduate of Northwestern University Medical School, Chicago.

****Boyd**
John R. Boyd, M.D., of Oak Park, died March 23, 1989 at the age of 85. Dr. Boyd was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

****Brodsky**
Abraham Brodsky, M.D., of Chicago, died February 4, 1989 at the age of 76. Dr. Brodsky was a 1937 graduate of the University of Illinois College of Medicine, Chicago.

****Chelecki**
Stefan Chelecki, M.D., of Madison, Wisconsin (formerly of Chicago), died January 17, 1989 at the age of 76. Dr. Chelecki was a 1937 graduate of Universita Degli Studi Di Bologna, Bologna, Italy.

****De Francois**
Walter De Francois, M.D., of Oak Park, died February 1, 1989 at the age of 85. Dr. De Francois was a 1930 graduate of Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania.

De La Vega
Raul E. De La Vega, M.D., of Danville, died January 20, 1989 at the age of 68. Dr. De La Vega was a 1946 graduate of Universidad de la Habana, Facultad de Ciencias, Escuela de Medicina y Estomatologia, Havana, Cuba.

Drill
Victor Alexander Drill, M.D., of Glenview, died December 4, 1988 at the age of 72. Dr. Drill was a 1948 graduate of Yale University School of Medicine, New Haven, Connecticut.

****Elliott**
Robert W. Elliott, M.D., of Alton, died March 23, 1989 at the age of 77. Dr. Elliott was a 1936 graduate of Washington University School of Medicine, St. Louis, Missouri.

****Entin**
Samson D. Entin, M.D. of Northbrook, died January 19, 1989 at the age of 78. Dr. Entin was a 1936 graduate of Loyola University Stritch School of Medicine, Chicago.

****Feinhandler**
Harold S. Feinhandler, M.D., of Chicago, died February 1, 1989 at the age of 80. Dr. Feinhandler was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

****Fineberg**
Henry H. Fineberg, M.D., of Glencoe, died March 20, 1989 at the age of 75. Dr. Fineberg was a 1939 graduate of Ohio State University College of Medicine, Columbus.

****Finola**
George C. Finola, M.D., of Lead, South Dakota (formerly of Chicago), died March 17, 1989 at the age of 87. Dr. Finola was a 1928 graduate of the University of Illinois College of Medicine, Chicago.

Garner
Katherine Rogers Garner, M.D., of Winnetka, died March 11, 1989 at the age of 92. Dr. Garner was a 1924 graduate of the Faculty of Medicine, University of Toronto, Toronto, Can.

Heinrich
Abraham H. Heinrich, M.D., of Lake Forest, died September 27, 1988 at the age of 85. Dr. Heinrich was a 1928 graduate of New York University School of Medicine, New York, New York.

****Hubata**
Joseph A. Hubata, M.D., of Russellville, Arkansas (formerly of Chicago), died March 18, 1989 at the age of 84. Dr. Hubata was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

***Krukas**
Emily Victoria Krukas, M.D., of Orland Park, died December 17, 1988 at the age of 85. Dr. Krukas was a 1941 graduate of the Chicago Medical School.

****Metsch**
Oswald Metsch, M.D., of Chicago, died February 19, 1989 at the age of 88. Dr. Metsch was a 1926 graduate of Medizinische Fakultat, Universitat Wien, Vienna, Austria.

***Mrazek**
Hazel S. Mrazek, M.D., of Riverside, died March 20, 1989 at the age of 68. Dr. Mrazek was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

Nguyen
Tuyen Minh Nguyen, M.D., of Danville, died December 31, 1988 at the age of 49. Dr. Nguyen was a 1968 graduate of the School of Medicine and Pharmacy, Medical University, Ho Chi Minh City, South Vietnam.

****Norak**
Walter Vincent Norak, M.D., died January 28, 1989 at the age of 77. Dr. Norak was a 1936 graduate of Chicago Medical School.

Rostenberg
Adolph Rostenberg, M.D., of Chicago, died November 3, 1988 at the age of 83. Dr. Rostenberg was a 1931 graduate of McGill University Faculty of Medicine, Montreal, Canada.

***Schlich**
Rossel Joseph A. Schlich, M.D., of Springfield, died January 20, 1989 at the age of 72. Dr. Schlich was a 1948 graduate of St. Louis University School of Medicine, St. Louis, Missouri.

****Soper**
Gail Raney Soper, M.D., of Evanston, died November 4, 1988 at the age of 91. Dr. Soper was a 1922 graduate of Rush Medical College, Chicago.

****Szanto**
Paul B. Szanto, M.D., of Chicago, died February 6, 1989, at the age of 84. Dr. Szanto was a 1929 graduate of Universitaet Wien, Medizinische Fakultaet, Vienna, Austria.

***Van Bergen**
Dr. William Van Bergen, M.D., of Effingham, died February 3, 1989 at the age of 54. Dr. Van Bergen was a 1959 graduate of Northwestern University Medical School, Chicago.

Waldinger
Clara Waldinger, M.D., of Chicago, died February 14, 1989 at the age of 84. Dr. Waldinger was a 1929 graduate of Medizinische Fakultat, Universitat Wien, Vienna, Austria.

***Yager**
Helmut Yager, M.D., of Oak Park, died January 5, 1989 at the age of 51. Dr. Yager was a 1978 graduate of Katholique Universitaire te Leuven, Faculte der Geneeskunde, Leuven, Belgium.

Challenges and Choices for the 1990s

The Illinois State Medical Society's All Member Conference
November 17 and 18, 1989
Hyatt Regency Oak Brook Hotel
Oak Brook, Illinois

Abortion: How it Affects the Illinois General Assembly





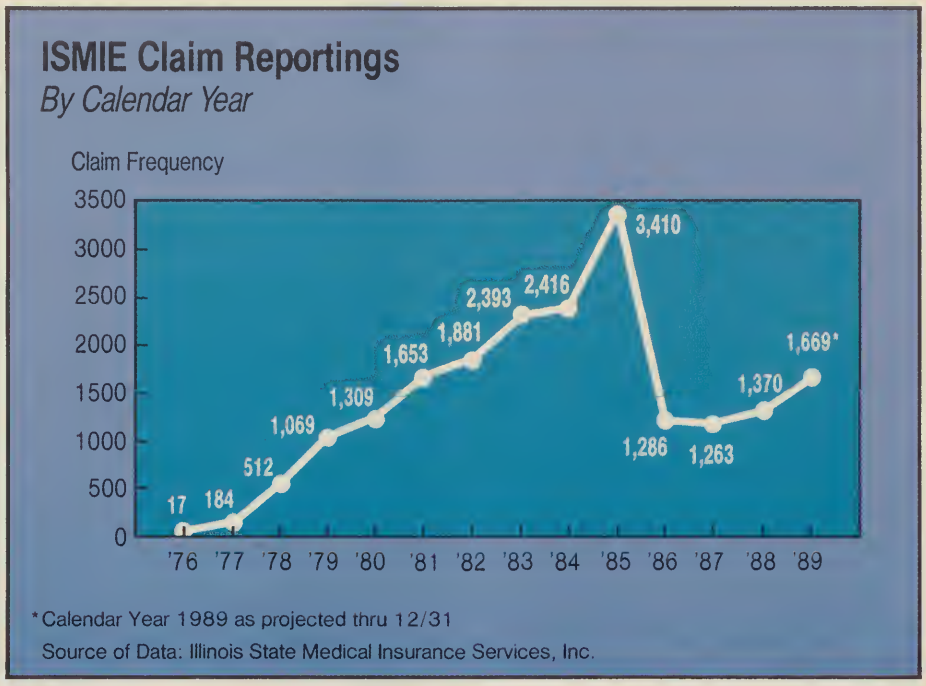
Saturday, Nov. 18 at 9:30 a.m.
State Representatives Barbara Flynn Currie (D-Chicago) and Thomas J. McCracken, Jr., (R-Westmont) will debate the effects of the U.S. Supreme Court's decision in *Webster vs. Reproductive Health Services* on Illinois elections and legislation.

For registration information, write or call:
Illinois State Medical Society
20 N. Michigan Ave., Suite 700
Chicago, IL 60602
(312) 782-1654 or (800) 782-4767

Part two of a series

ISMIE looks forward to future progress, service

by Eileen Norris



TODAY, the Exchange is seeing positive results from its 1985 tort reform efforts, says Robert C. Hamilton, M.D., chairman of Illinois State Medical Insurance Services, Inc., the management arm of the Illinois State Medical Inter-Insurance Exchange (ISMIE). He points out that the Illinois State Medical Society (ISMS) and the Exchange still are trying to get a $250,000 cap on non-economic damages, such as for pain and suffering.

After several up and down years, ISMIE's financial condition today is, "Beautiful, great," adds Fred Z. White, M.D., ISMIE's chairman. "We have $80 million in surplus and a better than two-to-one premium surplus ratio."

Dr Hamilton adds, "While the number of claims filed for the 1988-89 policy year is up slightly from the previous year, the trend is well below the pre-tort reform levels. Plus, the average indemnity paid on claims closed with indemnity is below last year's and the percentage of claims closed with indemnity is at 15.7 percent, which is very favorable compared to the actuarial assumption of 10 percent."

He also notes proudly that the financial analysis of the Exchange by the National Association of Insurance Commissioners has resulted in the best set of financial ratios for the Exchange in more than five years.

"We are solvent and looked upon favorably by the state insurance department," adds ISMIS director Phillip Boren, M.D., who attributes the positive conditions to conservative policies and reserve losses as well as strict underwriting.

In fact, John E. Washburn, until recently Illinois' insurance commissioner, says that although his department was very concerned about the Exchange when its surplus dipped in the past, he feels the company is on sound financial footing today.

"There has always been an onus for the bedpan mutual," he says, "but the Exchange has disproven that misnomer. It is really strong managerially and it's running the way it should be run. The number of claims has dropped, and I hear from those in the industry that the severity is beginning to go down slightly as well."

"ISMIE and the medical society can certainly be credited with getting the tort reform passed and that has helped the climate immensely," he says. "The climate is dictated by peo-

(continued on next page)

The grass *is* greener on the other side

by Eileen Norris

An Indiana cardiologist was complaining recently to a colleague physician in Illinois that his malpractice insurance premium was going to $1,000 and that he would have to pay his insurer $3,000 for the upcoming policy year. The response from his Illinois friend was envy—pure and simple green envy.

"I told him that I pay $12,000 a year plus tail coverage, which brings it up to at least $18,000 a year. And I'm in internal medicine," relates an incredulous Larry Jennings, M.D., who practices in Mt. Carmel, a Southern Illinois town which sits across the border from neighboring Indiana.

A handful of doctors are actually pulling up their Illinois stakes and moving to Indiana because of that state's considerably lower premium rates and because doctors are less vulnerable there to multi-million dollar malpractice awards. Indiana, in fact, has a $500,000 cap on damages in malpractice suits.

Some specialists, particularly those practicing in semi-rural areas, say they can't justify the insurance premiums they are being asked to pay.

Joseph Mohammed, M.D., an OB/GYN and a colleague of Dr. Jennings at Mt. Carmel, says he "jumped the river—the Wabash River," which separates the two states at their southern tips, about a year ago. Luckily he has retained about 40 percent of his patients, those who are willing to travel the 30 miles each way for their visits.

"My commercial carrier charged me $4,840 a year in 1983 and projected it would be $18,000 by 1988," says Dr. Mohammed. "But in 1987, they came back with a premium of $102,000 and I said, 'The hell with it, I'm moving'."

Dr. Mohammed points out that he has been sued once in the last nine years and that case was thrown out of court. "I didn't cost that carrier one penny," he says angrily. When he settled into his new partnership practice in Vincennes, Indiana, Dr. Mohammed happily shelled out his total premium for the year: $20,000 which is less than one-fourth of what he would have paid if he remained in Illinois.

In fact, the Indiana Insurance Department claims its malpractice insurance rates are close to being the lowest in the nation, second only to North Dakota's. "It's an attractive place to do business," says Keith Kendall, an administrative officer in the department's company services division.

Indeed, Michael Blood, M.D., a family practitioner, who moved in April to Crawfordsville, Indiana, which is west of Indianapolis, says recruiters told him they are placing more doctors in Indiana than any other state.

Dr. Blood's move out of Illinois was prompted more by the troubled economy in southern Illinois than by the malpractice climate, but he's still glad to see his premium reduced by about $2,500. He's paying $6,000 instead of the $8,500 he paid in Illinois. "But it's really comparing apples and oranges," he adds, "because my insurance was claims-made before and now it's an occurrence policy".

How does Indiana do it? And why can't Illinois achieve the same thing?

Indiana is a better place to practice from the point of medical malpractice, but there are historical reasons for it, says Phillip Boren, M.D., an Illinois State Medical Society trustee who practices in Carmi, Illinois, about eight miles from the Indiana border.

"Every state reacted differently to the malpractice crisis in the mid-70s," says Dr. Boren. "And of all the states involved with tort reform, Indiana has probably been the most successful."

At the time of the liability crisis, when not only insurance affordability but availability became issues for many physicians, Indiana was fortunate to have an ally in Governor Otis Bowen, himself a physician. Not only did Dr. Bowen see to it that key tort reform was passed in the legislature, but he also was able to hand-pick state Supreme Court justices who shared his perspective on civil justice issues.

"The governor was also able to get pieces of legislation passed that created the patient compensation fund (PCF), whereby anything over the basic $100,000 policy was paid for out of the fund," says Dr. Boren. Doctors who choose to participate in the PCF, says Kendall of the state insurance department, are surcharged 125 percent on their underlying premium so that the maximum award against them is limited to $100,000, with the PCF coming in to cover $400,000 on top of that.

The state also has a $500,000 cap on damages, which has been a tremendous help in keeping judgments down. Recently passed legislation that will be effective January 1, 1990, increased that maximum on damages to $750,000, a move that Indiana physicians realize also will eventually affect their premium levels.

"The cost to providers will go up," says Kendall of the insurance department. "The 125 percent surcharge to physicians participating in the PCF will have to be increased to fund that additional liability."

He says the surcharge can be raised as high as 200 percent, but he points out that even with an increased total premium, Indiana is still radically cheaper than Illinois for medical malpractice insurance. "The $750,000 cap on damages concerns me," says Dr. Mohammed, who doesn't like to see Indiana backpeddle on any of its conservative reforms. "Still, it won't be as bad as Illinois," he adds.

There are other reasons for Indiana's desirable malpractice atmosphere. Besides the PCF and the cap on damages, neither of which Illinois has been able to get approved through its legislature, Indiana also has a screening panel that rules on the merit of claims before they get to court. Dr. Boren says Illinois' screening panel has been ruled unconstitutional not once, but twice.

Even though Illinois' malpractice environment isn't perfect, Dr. Jennings says he's encouraged by what he sees. "When you look at the big picture, maybe we—patients, lawyers and doctors—have all lost a sense of what justice is. It's societal problem, but I still believe Indiana has a good deal and I'd like to see it in Illinois." ▲

ISMIE

(continued from page 6)

ple's expectations. And I believe the general public is realizing suits aren't free. We all pay."

That sentiment is echoed by Dr. Hamilton. "Consumers in general have seen the effects of the liability crisis and are becoming aware of what the liability crisis has meant. They know it's just not a liability crisis in the medical field when they see the closing of their playgrounds and discontinued athletic teams. That strikes a chord with people."

"We have come a long way, but we have a long way to go," says Dr. Boren. "We want to improve the climate even further. And the cap on non-economic damages is our number one priority which we fully hope to implement in Illinois," he adds.

The goals for the Exchange, says Dr. Hamilton, are really unchanged since the company was started more than a decade ago.

"Our goal was and is to have a solvent, dependable company with the resources to defend and to indemnify our policyholders," he says. "We are really the only company offering professional liability insurance to physicians in the state which has continuous, unmodified availability to doctors. Some carriers have left the state and some have come back while others have decreased the amount or type of coverage. We have been here and will continue to be here indefinitely."

Dr. Boren adds, "When we started the company, one of the goals was to create a company that behaved differently than commercial carriers and we have done that.

"We don't increase premiums to make up for investment losses so that premiums aren't dependent on market conditions," he says. "And we will continue to invest premiums very conservatively so that we will be less subject to the ups and downs of the property/casualty cycle."

We are solvent and looked upon favorably by the state insurance department.

Dr. Hamilton points out that because ISMIE has no insurance agents acting as middle men, the organization's ratio of administrative expenses to the total premiums earned has always been less than six percent, which compares very favorably with other physician-owned carriers and the "upwards of 20 percent ratio we see with commercial insurers," says Dr. Hamilton. "The premium goes to defense expenses and indemnity payments rather than commission.

"Our investments are primarily in bonds, which have been purchased to mature at the time when we project we'll need the cash," Dr. Hamilton adds. "That way we don't have to worry about market fluctuations in value of the money."

ISMIE founders believe they can do the job better, thanks to the Exchange's own data base which tracks experience and risks and the background in medical malpractice to underwrite new procedures and activities that technology offers physicians.

"We can do this with reasonable underwriting skill because of our physician consultants," points out Dr. Boren.

"We also want to offer innovative insurance which will parallel the changes in physician practice patterns," says Dr. Hamilton. "Even though we will never cease to offer coverage to individuals or small groups, we will emphasize physicians practicing in groups more in the future."

ISMIE will continue to concentrate on loss prevention and risk management, two of the most important fields by which physicians can decrease the incidence of not just suits but occurrences that might lead to suit, says Dr. Hamilton. "With our data base we know where the risks are," he adds, "because we're dealing with only Illinois' experience." ▲

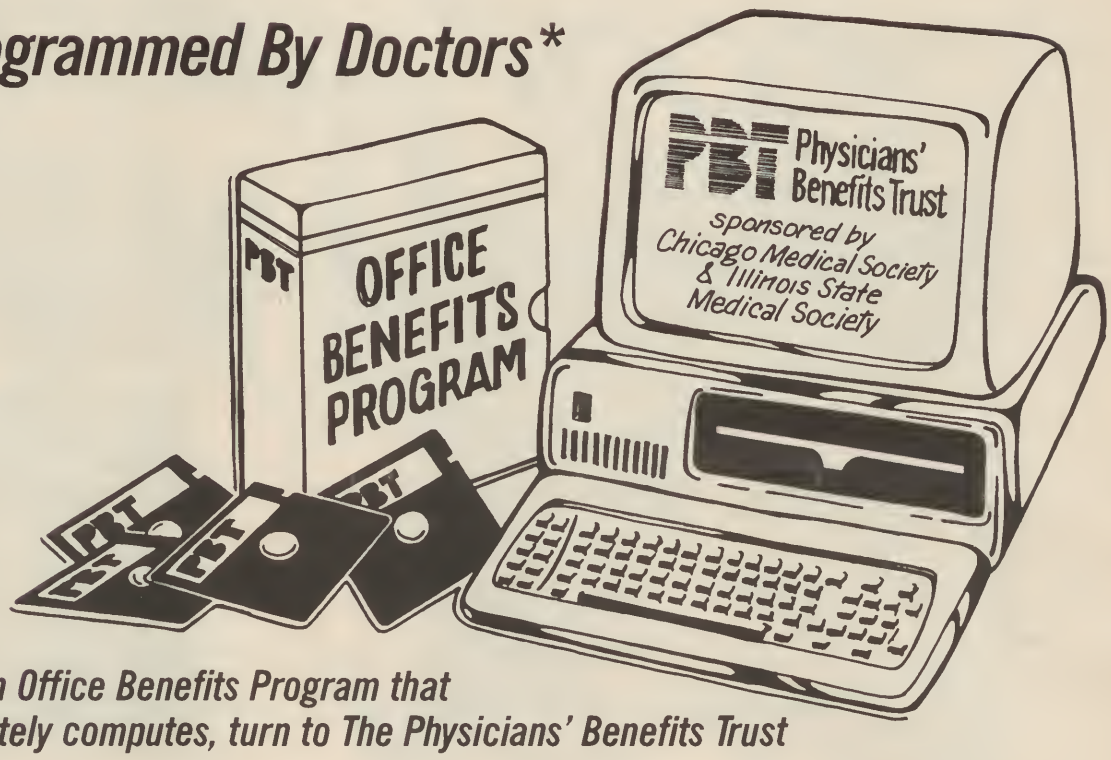
Exchange Q&A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *I occasionally send a letter requesting policy changes with my premium payment. Is this acceptable?*

A: It's best not to send them together. Any correspondence regarding policy changes should be sent directly to the underwriting department at ISMIE, 20 North Michigan, Suite 700, Chicago, Illinois 60602. Premium payments are directed to a bank lock box. Any correspondence you send with the payment will be routed to ISMIE underwriters, but this will delay the processing of your request. ▲

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Ritual child abuse and satanic cults: a growing menace

by Franklin J. Kourt

WE'VE READ about the phenomenon in the general press, seen programs devoted to it on network television; yet this particular problem is one whose details, and long-term implications, are simply too horrific for many of us to contemplate. It is the incidence of ritual child abuse, generally related to the secret satanic cults quietly operating in Illinois and throughout the nation. This phenomenon, which has come to public attention through a number of recent sensational news reports, is not limited to major cities; in fact, its existence is believed strongest in small towns and rural areas. And it is a menace which more and more physicians will be facing in the future.

Ritual abuse showing up in practice

Bennett G. Braun, M.D., medical director of the dissociative disorder program at Chicago's Rush-Presbyterian-Saint Luke's Medical Center in Chicago, and instructor in psychiatry at Rush Medical School, is one of a handful of national authorities on treatment of ritual child abuse victims.

Dr. Braun says he has treated over 100 cases of such abuse over the past five years, and sees it as a growing, though difficult to quantify problem, as few reliable statistics exist. At first, Dr. Braun says, he tended to dismiss stories he heard of satanic cults, but then found signs of such activity in the patients he treated time and again. "And then you can't deny it," he says. "One of the ways," says Dr. Braun, "that [satanism] has been passed off and pooh-poohed is by adults saying, 'The children are talking to each other.' But they're all reporting very similar phenomena. There's too much there to put it off to hysteria."

Similarly, counselors working with ostensibly unrelated disorders like alcoholism and drug abuse are finding more and more evidence of ritual abuse in children and teenagers.

"A good 30 percent of our patients," says Carla M. Morris, assistant director of the Lifeway adolescent chemical dependency center in Pekin, "have experimented with satanism beyond dabbling; and a good 50 percent come in with symbols, or writing, on folders, with poetry, or with writing on their bodies, which gives us cause to ask them about it." Lifeway is affiliated with and operates out of Pekin Memorial Hospital.

Morris, a certified addictions counselor, says she is finding more and more evidence of satanic and ritual abuse in her patients. "Young people's involvement in satanism is a growing problem," she says. "We've increased our awareness of it. We've been open five years, and I would say over the last two years there's been a sharp increase in this kind of thing. Parents go through their kids' rooms and find all sorts of paraphernalia, satanic bibles and books on witchcraft."

Law enforcement follows the trail

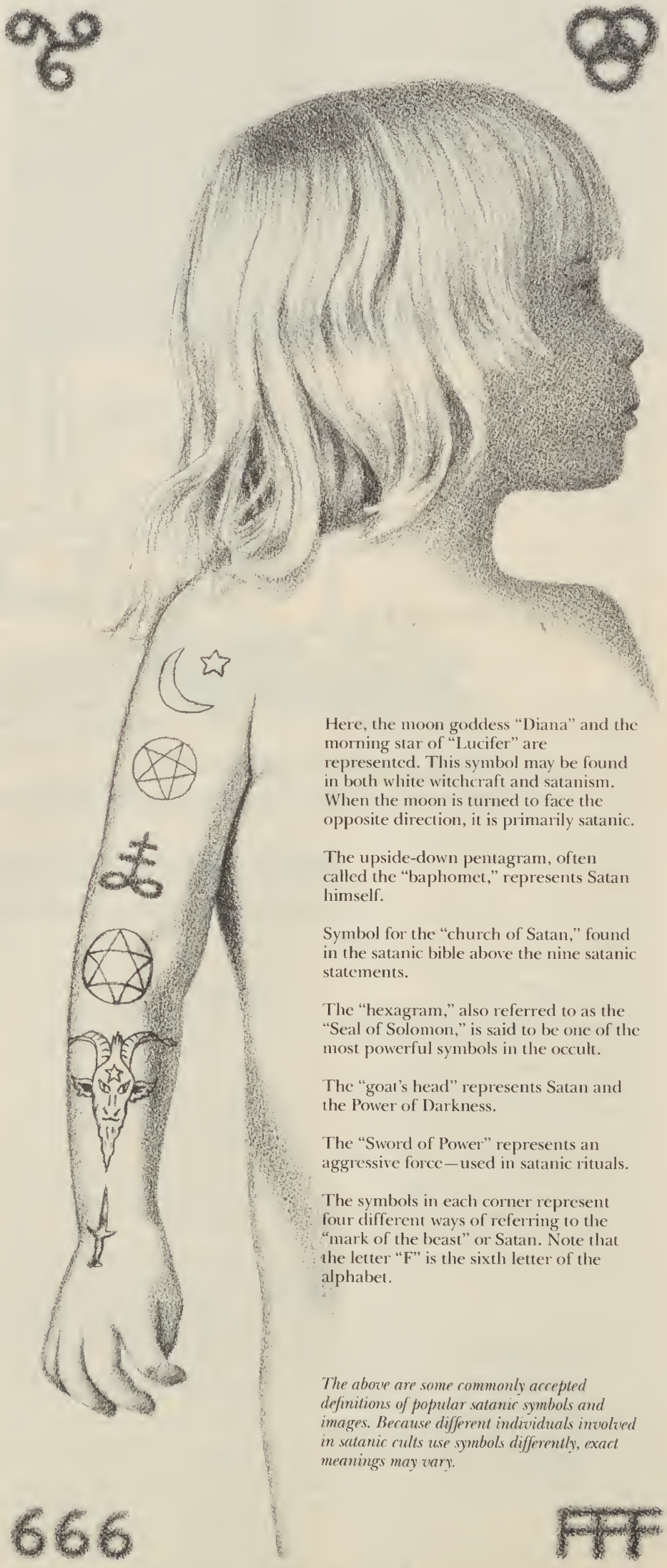
While health care professionals encounter evidence of the destructive effects of satanic cult activity in patients, both on a physical and mental plane, law enforcement officials are responding to reports and complaints from local residents of cult activity in towns and in rural Illinois.

In Rockford, Winnebago County state's attorney Paul Logli says, "We are constantly hearing stories of people gathering in remote places. We have found satanic graffiti on barns that have been burned out. Now and then, we'll hear from a child victim of sexual abuse who will tell us stories that would indicate that there has been some ritualistic sexual abuse as well."

Glenna Sparks, a special agent with the child exploitation unit of the Illinois state police, says she has personally been involved in the investigation of about five cases of child abuse by satanic cults in the past year.

Sparks tells the story of one seven-year-old boy "who said he had been made to sacrifice an infant during a satanic ceremony, at which his nine-year-old brother was also present. We believe the event actually occurred," she says, "because the siblings, along with two other children we interviewed, described the same events, and both children drew pictures of human skin in layers, a knowledge about anatomy most children that age simply don't possess."

Sparks says law enforcement officials are looking into satanic activity in diverse areas of Illinois. "I am familiar with cases in the western part of the state," she says, "including Lake County and the Antioch area, and I understand there has been activity noted in the Galena area, DeKalb and Will Counties, and the Rockford area." Sparks adds that all these areas include some woods or forests, which are frequently chosen as sites for satanic ceremonies.



Here, the moon goddess "Diana" and the morning star of "Lucifer" are represented. This symbol may be found in both white witchcraft and satanism. When the moon is turned to face the opposite direction, it is primarily satanic.

The upside-down pentagram, often called the "baphomet," represents Satan himself.

Symbol for the "church of Satan," found in the satanic bible above the nine satanic statements.

The "hexagram," also referred to as the "Seal of Solomon," is said to be one of the most powerful symbols in the occult.

The "goat's head" represents Satan and the Power of Darkness.

The "Sword of Power" represents an aggressive force—used in satanic rituals.

The symbols in each corner represent four different ways of referring to the "mark of the beast" or Satan. Note that the letter "F" is the sixth letter of the alphabet.

The above are some commonly accepted definitions of popular satanic symbols and images. Because different individuals involved in satanic cults use symbols differently, exact meanings may vary.

Fact or fiction?

While law enforcement officials and health care professionals struggle each in their own ways to deal with this growing horror story, it becomes more and more important for all those involved to listen with ears of calm reason and compassion. How does one separate wild tales from actual occurrences?

"It takes a very trained ear and both feet on the ground to identify the difference between fact, fiction and fantasy. One must very soundly use common sense to try to aid these kids," says Dale Griffith, Ph.D., a Tifflin, Ohio, expert on satanic cults who holds a doctorate in psychology and criminal justice and lectures widely on the subject. "But we must aid these survivors any way that we can." Dr. Griffith delivered a seminar on the topic for health care professionals and law enforcement officials in Macomb earlier this year, and travels throughout the Midwest spreading knowledge on the topic.

"In my experience," says Dr. Griffith, echoing the local findings of Carla Morris at the Lifeway center in Pekin, "over 60 percent of adolescents in drug and alcohol treatment programs have been involved in some aspect of the occult."

The drug- and alcohol-abuse connection, which a number of health care professionals have noted, is one which seems to confirm the horribly destructive psychological effects that ritual abuse can have on children and young people. In addition, says Dr. Braun, victims of the most severe forms of ritualistic abuse sometimes

(continued on next page)

(continued from page 8)

develop multiple personalities as escape mechanisms. "You can't run away physically, so you run away in your mind," Dr. Braun says, adding that results of two studies he has conducted on the subject show that about 25 percent of the patients with multiple personalities have been the victims of ritualistic abuse.

Treatment: the options

Treatment, says Dr. Braun, consists of a long process of psychotherapy with the use of medication to make patients more amenable to the therapy. He adds that many of the severe cases he deals with are suicidal and require hospitalization during treatment. Still, a number of his patients have gotten out from under the terrible burden of an abused past, and learned slowly to reenter mainstream society.

"I think we need to believe the children," Dr. Braun says. "Not everything that's said is true and there's going to be some hysteria. We've got to be calm, to get our facts straight. But to deny [that such abuse is occurring] would be a terrible disservice."

In the meantime, says Dr. Braun, we must remain patient in our attempts to clear society of this dreadful phenomenon. Cult activity, he points out, is nothing new, and has been around since the Middle Ages, probably arriving in the Americas from Europe. A number of ritualistic cult practices and traditions also came to South America and the Caribbean from Africa. "If it didn't come over on the Mayflower, it probably came over shortly thereafter," he concludes. ▲

Recognizing potential signs of ritual abuse

HOW DOES one recognize a victim of ritualistic child abuse?

It's not easy, says Bennett G. Braun, M.D., a Chicago psychiatrist and authority on treating such victims, but there are "indexes of suspicion" that can help.

According to Dr. Braun, it's particularly difficult for a physician to identify children who have been ritually abused, because they are often not brought to physicians. There are, however, some signs that might lead to such identification.

If a child shows evidence of having sustained multiple fractures at different ages or displays odd things like bite marks, these should be viewed, while not conclusive, he believes, as indexes of suspicion.

Dr. Braun says suicidal tendencies in young children, especially those in the 3-6 age group, present a high index of suspicion. "This is not true of every child who is suicidal, but it will raise your index of suspicion."

Also, older children who write or read backwards might raise suspicion if dyslexia is ruled out, because part of the conditioning of children by some cults involves learning to do things backwards. Dr. Braun stresses that this does not mean that every child who displays such a tendency is a victim of ritualistic abuse.

Another thing to look for is children who are consistently hurt or appear "accident-prone" around Halloween, Christmas or Easter, or between the months of July and August, since these are traditionally times that some cults hold ceremonies commemorating "sabbats," or observing equinoxes and solstices, Dr. Braun says. ▲

County news

by Kevin M. Kelleghan

Winnebago County Medical Society hosts kickoff

In a first-ever event, Rockford's two top civic leaders challenged local physicians to dig deeper into their community with both time and money when the Winnebago County Medical Society held its annual fall kickoff dinner September 27.

The doctors brought the lectures on themselves when they invited freshman Mayor Charles E. Box and recently-hired district 205 School Superintendent Maurice Sullivan to discuss city and school problems. Sullivan sent his deputy, 30-year public schools veteran Bill Bowen. Together, Box and Bowen addressed a record turnout.

It was the most significant episode in a relatively recent public relations effort "to involve physicians in the community to build lines of communication so we aren't just going to the community on physician economic issues," according to Winnebago County Medical Society executive administrator Bob Carlson.

Medical society president Robert Bertrand, M.D., triggered the new strategy when he began a series of interviews early this year with community leaders in his editorial space in the society's monthly newsletter.

In the first interview outgoing Mayor John McNamera charged doctors—and lawyers—of not being involved in their own community.

Bertrand published that, then asked the new mayor, inaugurated last April, to share his wish list with the medical community.

Mayor Box urged the physicians present to take action to benefit the community. Among the specific actions the mayor urged that doctors:



Jon McGinty

Winnebago County Medical Society president Robert Bertrand, M.D. (center) greets Mayor Charles Box (right) and deputy school superintendent Bill Bowen.

- Join the Rockford Area Substance Abuse Council.
- Meet with the Red Cross to develop an emergency plan to deal with a crisis such as the recent Hurricane Hugo devastation.
- Contribute time, expertise and funds for the homeless, 120 pregnant teens, the hunger task force, the council on aging, and renovation of boarded-up buildings.

Deputy School Superintendent Bowen tacked on six more "volunteer jobs" for doctors. Among them:

- Running for the school board.
- Sharing knowledge as visiting teachers.
- Sharing expertise on substance abuse in elementary schools.

Winnebago County doctors are already involved, Carlson pointed out. The current and past president and first vice president of the medical society sit on the Rockford Council for Affordable Health Care, a local business coalition founded to study health care's impact on business.

Doctors also make the rounds in schools to discuss AIDS, adolescent health, sexuality and teen suicide, and visit seniors with free answers to health questions, Carlson said. ▲

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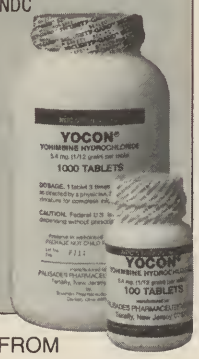
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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Western Illinois IPA hit with financial and procedural crises

by Karen Beshears

NEWS OF a massive financial loss in 1988 and conflict over a memo about what doctors tell patients denied HMO coverage has had members of the Western Illinois Independent Physicians Association (IPA) in an uproar.

The IPA, which represents 208 physicians in Rock Island and Henry Counties, contracts with the Heritage National Health Plan, a health maintenance organization which is also a Deere and Co. subsidiary, to provide care to about 40,000 employees and retirees of area businesses.

In 1988, the IPA lost a total of $845,708 on a Heritage contract of $12,106,000. Yet Heritage has not provided the final figures, say IPA leaders, so that loss could grow still larger.

That financial loss and other IPA actions have some doctors concerned that the IPA is expending so much energy worrying about cost control that it could allow the quality of care in the HMO to suffer. Paradoxically, they also fear that unless costs are addressed, the same result could take place.

The loss, plus two memos about doctors talking to patients and a new set of cost-containment procedures which require pre-certification of certain procedures and of all non-emergency admissions, are individual elements which appear to be linked in the doctors' minds.

Memos on patient communications

First, there are those memos.

IPA physician members received a letter dated March 3, 1989, by certified mail, from the IPA peer review committee. The letter appeared on IPA stationery, but listed the Heritage address. The subject was "penalty for physician-patient communication."

Eduardo A. Ricaurte, M.D., psychiatrist and IPA president, said the memo was sent by a Heritage clerk after an IPA board meeting, initialed by the IPA peer review chairman J. H. Gardner, M.D., but without board clearance.

IPA executive director Douglas S. Arnold called the memo "frankly poor communications."

The memo was the result of IPA board discussion of a doctor's prescribing of drugs which the peer review committee had questioned. The doctor involved had refused to answer committee questions, then cut the patient off the drugs completely, instead of gradually, which constituted inappropriate treatment, Dr. Ricaurte said.

"He told the patient, 'I can't do this because [the IPA] tells me I can't'," said Hal Bergee, M.D., radiologist and IPA vice-president. The board was threatened with a suit by the patient. Arnold said concerns about IPA liability then led to the policy.

The memo summarized by the Heritage clerk read in part:

"The entire general membership will be advised of the implementation of a warning system.



This notification will be sent via certified mail to ascertain all physicians are aware of the new policy.

"Should a physician openly and freely discuss the peer review/physician correspondence and activities with an enrollee, in a malicious manner that may result in an unfavorable relationship among all parties, a fine of $1,000 will be assessed.

"If the aberrant behavior of the physician occurs a second time, the incident will be reviewed by the committee for recommendations to the board of possible suspension of the physician from the IPA."

IPA officials were bombarded with phone calls questioning the policy. After a mass meeting of the membership in which Dr. Gardner came to the podium wearing a construction worker's hard hat to add some humour to the scene, doctors cooled down. Arnold and other IPA leaders explained the incidents leading to the policy.

Seeking to provide written clarification, the IPA issued another letter dated April 6, which also had comprehensibility gaps, and included the following:

"The peer review process and peer review communications are privileged. Peer review decisions regarding payment may be communicated to patients, so long as such communication is not done in a disparaging manner. Disparagement is prohibited by the IPA bylaws."

The only part of the IPA bylaws which mentions disparagement is under Section 5, "Termination of Members." Members can be dropped for "failure to cooperate with the corporation and its members in working towards the objectives of the IPA-HMO approach to medical care, or disparagement of these objectives or various subscriber organizations under contract with the corporation to enrollees or others."

"It is appropriate to communicate payment and/or coverage decisions to patients . . . Such information may indicate whether an admission will be certified for coverage and whether any decision regarding certification has been appealed."

Memos confuse the issues

Judee Gallagher, a Chicago attorney who specializes in physician contracts, has offered her legal opinion on the Western IPA memos. She uses the term utilization review to describe the process involved, which is part of what the IPA peer review committee does.

She sees four areas as crucially important in analyzing utilization—privilege, IPA malpractice liability, penalty, and the memos themselves.

"The Illinois Medical Studies Act provides that reports and statements of a utilization review committee 'used in the course of internal quality control' or for 'improving patient care' are privileged," Gallagher says. "This means that a plaintiff would effectively be denied access to the privileged information because it is not admissable evidence and not subject to 'discovery.' An issue yet to receive judicial scrutiny is the appli-

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(continued from page 10)

cability of the privilege to utilization review where the focus of the review is cost containment rather than improving patient care," continues Gallagher.

"It is unclear," says Gallagher, "whether the IPA's utilization review focuses on improving patient care or cost containment. So it is unclear whether all the utilization review communications are privileged.

"Financial penalties like this one could come back to haunt the IPA [in malpractice liability]," she says. "Suppose the IPA denies certification for a recommended treatment and the physician does not vigorously protest the denial because of the confusion surrounding the penalty for physician-patient communication. If the patient forgoes the treatment and an injury results, the patient may sue the IPA, alleging that the penalty was 'a significant causative factor' in the physician's failure to provide the recommended treatment.

"It is not uncommon for IPAs or HMOs to penalize physicians for failure to comply with utilization review procedures," says Gallagher. "[But] to penalize physicians for physician-patient communications regarding utilization review decisions is misguided," she says.

"The unique character of the physician-patient relationship creates a duty on the part of the physician to inform the patient when an IPA/HMO has refused to certify [i.e., pay for] recommended treatment," she says. "The physician also has a duty to vigorously protest the certification denial. Additionally, the physician should document the conversations with the patient and the protest in the patient's medical record.

"The penalty could have a chilling effect on this type of physician-patient communication, and inadvertently result in the patients not being properly informed about their health care needs.

"The memos explaining the penalty are confusing. An IPA like everyone else has a right to protect itself from libel and slander," she says. "But they seem to confuse complex issues and do not define terms, like 'what is disparagement'?"

"The penalty [for unauthorized communication] could . . . result in the patients not being properly informed about their health care needs."

The quandary over cost controls

The Western Illinois IPA has taken several steps to ensure its financial survival. The board—which all interviewed doctors praised even though disagreeing about the memos—negotiated a 16-percent increase in the HMO contract for 1989 to cover 40,000-plus enrollees for Heritage.

The IPA also boosts its income through contracts with other insurance firms or health care providers.

This is the first year the IPA has agreed with Heritage to pre-certify non-emergency admissions, even though it was already required by another insurer. Certain other procedures, including endoscopy, also require pre-certification.

Mike Hammes, Heritage president, says rising utilization caused the company to press for pre-certification. Hospital inpatients, for instance, for all Quad-Cities patients (which include the 60,000-plus enrollees also served by two other IPAs) rose from an average of 421 inpatient days per 1,000 enrollees in 1987 to 491 days in 1988. Since pre-certified admissions started earlier this year the average is between 420 to 450 days, a clear savings, he said.

Utilization of other services rose dramatically between 1987 and 1988, Hammes says. For instance, ingredients for and prescriptions of drugs rose 24-percent in cost, and out-patient hospital care, including ambulatory surgery, diagnostic services, therapies, and emergency room use rose 21-percent.

However, 1988 was the first year that Heritage, the 25th-largest HMO in the nation, showed a bottom-line profit since it was formed in 1985. It showed a net profit of $200,000 in FY 1988 compared to losses of $1.3 million in FY 1987 and $1 million in FY 1986. "The plan depends on the doctors to be successful," Hammes says. "Doctors control 95-percent of health care dollars."

While Hammes doesn't consider the doctor/HMO relationship as adversarial, doctors say otherwise.

"We passed the honeymoon stage and are at the staring-across-the-table stage," said Dr. Gardner. "They're an insurance company. We want to have our fees paid. As a group, the doctors and the HMO have tried to control costs. Ninety percent of the doctors have done a great job. I can see when Heritage might not contract with the IPA."

In earlier days, the IPA was a more altruistic organization, says Mike Gerdes, M.D., an orthopedic surgeon who says he is an IPA member by necessity, not choice. He believes that the board has "focused on the economics of medicine rather than quality of care."

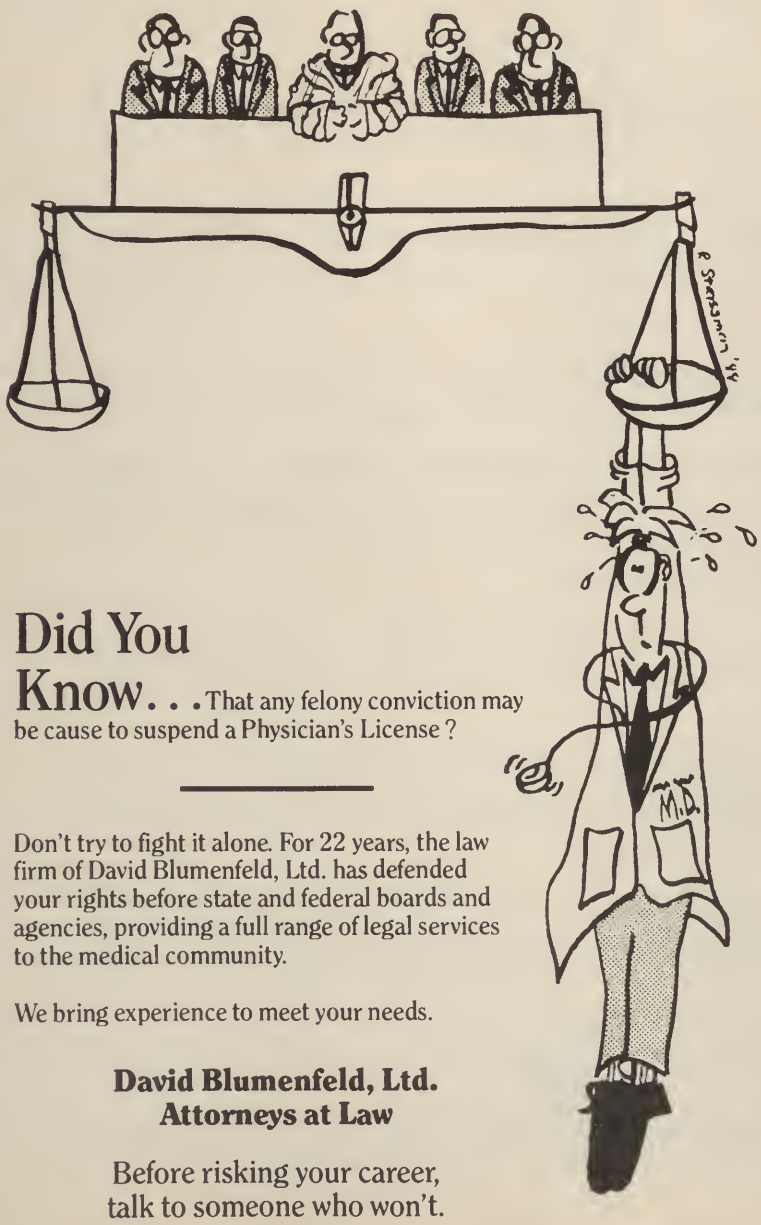
The IPA uses such policies as the patient-doctor communication penalty and a new limited fee range because "legally, they have no way to weed out the bad apples," Dr. Gerdes said. "There's differences in practice needs, they're trying to homogenize people."

Philip Seigert, M.D., surgeon and IPA member, says some physicians do abuse the system, collecting more for treatment than deserved, but he'd like to see the IPA do a better job as bargaining agent to ensure the future.

But "doctors aren't economists," and should stay out of the cost control side of medicine, says Dr. Seigert, an orthopedic surgeon.

A family practitioner said the IPA actions are just part of tremendous changes in health care. "It's not all terrible," says Bruce Steffens, M.D. "It's not terrible to have to defend my actions . . . I may not appreciate it . . . but it's good for the patient."

"No organization can continue to lose money except the government," Dr. Steffens says. "Either the IPA will get its act together and learn how to utilize the data, or not. One year isn't going to break them, but a second year might." ▲



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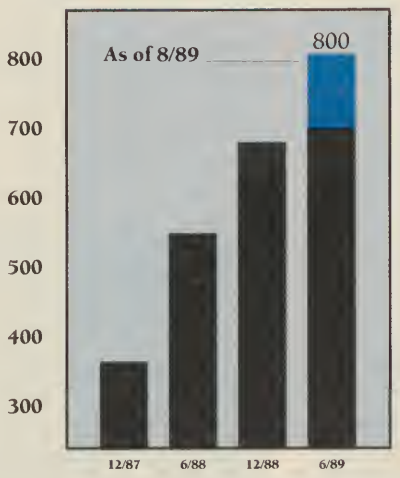
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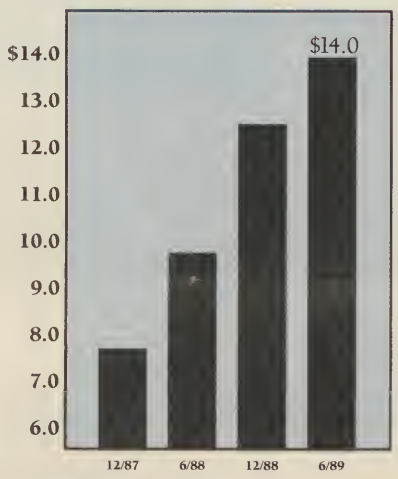
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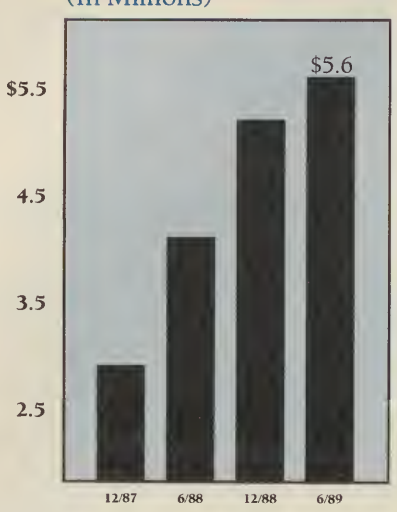
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(continued from page 2)

licensure as a result of the new regulations. As of Oct. 19, there were 47 licensed ASTCs, most of which are licensed to perform multiple procedures.

The new rules create a mechanism for approving the surgical procedures such centers can perform. They clarify who is to be licensed, and the initial licensing procedures and requirements for pre-operative and post-operative evaluations.

Adoption of the amendments by the Ambulatory Surgical Treatment Center Licensing Board came on May 31, after more than a year of discussions and hearings involving IDPH and health care providers.

Medicare-certified ASCs must seek licensure

The new rules expand the definition of ASTCs to include outpatient surgery centers that are certified by the U.S. Health Care Financing Administration (HCFA) to receive Medicare facility reimbursement as ambulatory surgical centers (ASCs), but which may not now be licensed by the state.

"Prior to this regulation, there were centers that met the federal definition and were able to charge a [Medicare and ASC] facility fee, but were not required to be licensed," said Dr. Lumpkin.

In addition to requiring ASCs to be licensed, the new rules address the issue of surgical suites in physicians' offices. From now on, a license will be needed for any office, portion of an office (surgical suite, etc.), or building used by physicians or podiatrists to perform surgical procedures, if the surgical procedures constitute more than 50 percent of the total activities at the physician's or group's office. This provision applies whether or not the institution or building housing the licensed area is itself licensed as an ASTC.

Finally, any office or building which permits providers outside the group or practice to utilize its surgical facilities will have to be licensed as an ASTC. Exemptions to ASTC licensure include hospitals, long-term care facilities, state and federal facilities, and dental surgery facilities.

Mark Mayo, executive director of the Illinois Freestanding Surgery Center Association (IFSCA), says that while he understands the need for IDPH to change some of its rules, he fears the public may experience some confusion.

"The concern we have expressed is that [the rule change] creates some confusion on the part of the public because you'll have facilities that will now be licensed as surgery centers that heretofore would have been considered doctors' offices," says Mayo. IFSCA represents 20 of the 47 centers currently licensed as ASTCs.

Dr. Lumpkin said IDPH believes public confusion most likely now exists in those instances where facilities are perceived to be licensed ASTCs simply because they have federal certification, but in reality are not.

Mechanism for approving surgeries

The new rules also create a mechanism for IDPH to review surgical procedures performed by ASTCs. Formerly, ASTC license applicants, as well as already-licensed ASTCs that propose to perform additional procedures, were required to submit a list of proposed procedures for IDPH review and approval. However, no approval process for IDPH to follow was specified.

Under the new rules, IDPH will review proposed procedures and disapprove any procedure it feels may not be performed safely on an outpatient basis, or "which it finds is generally emergency or life-threatening in nature." The rules say that IDPH may consider HCFA guidelines that identify Medicare-covered procedures, but is not bound to follow them when making its own determination.

If IDPH questions a procedure, it must now follow a specified process when deciding whether to approve the procedure. The process involves seeking additional information about the procedure from the center, as well as consulting with independent specialists and the available literature about the procedure.

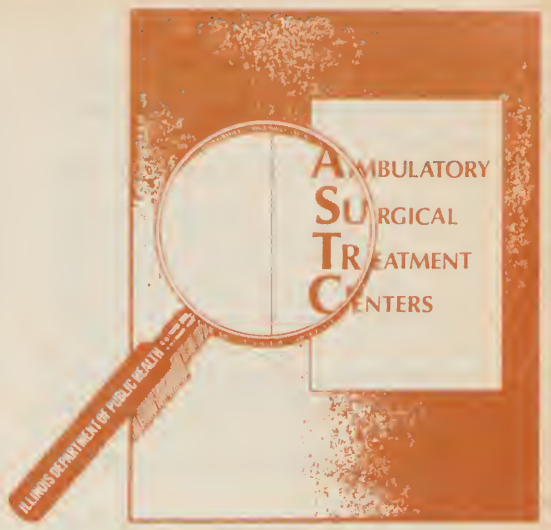
The new rules also allow IDPH to grant conditional approval of the procedure pending quarterly reports from the center regarding its experience with the procedure. If a death or complication resulting in a patient's emergency hospital admission occurs, the center must notify the department within 24 hours.

A meeting between the center and the IDPH will then be scheduled to discuss continuing conditional approval of the procedure. IDPH will grant final approval when it is satisfied the center has established the safety of the procedure. There is also a process for appealing any IDPH decision.

The review process is cumbersome, IFSCA's Mayo said. He also questioned IDPH's authority to pre-approve surgical procedures. He said that right belongs to a given facility's consulting committee, which used to be required to review a center's list of proposed procedures and certify their safety to IDPH.

"The state has a right to review those lists, but before this rule came into place there was, in our opinion, neither statutory [authority] nor a ruling that allowed the department to pre-approve certain procedures," said Mayo.

Dr. Lumpkin countered that the new rules were approved by the Joint Committee on Administrative Rules, a bi-partisan committee of the General Assembly that exists to ensure regulations drafted by state departments fall within the scope of the original statutes. "So it really is our feeling that [the rules] fit within the scope of the ASTC Act," said Dr. Lumpkin. ▲



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Rural health bills

(continued from page 1)

one signed outright by the governor and two amendatorily vetoed) are as follows:

H.B. 1494: Signed outright. This bill creates a loan repayment program for primary care physicians who agree to practice in underserved areas for no less than two years. The maximum annual payment will be $20,000 or 25 percent of medical school indebtedness per year, whichever is less. ISMS supported the bill, which was sponsored by Rep. Thomas J. Homer (D-Canton) and by Sen. Rea.

H.B. 421: Amendatory veto accepted by legislature. This bill, the Illinois Rural Health Act, expands the duties of the center for rural health at the Illinois Department of Public Health (IDPH) to include information and technical assistance to rural communities. The governor scrapped a provision supplying helicopters for non-emergency health purposes and transportation of state university medical school personnel in planning or delivering medical care. H.B. 421 was sponsored by Rep. David D. Phelps (D-Eldorado) and by Sen. Rea.

S.B. 1305: Amendatory veto accepted. The bill allows taxpayers to donate one dollar or more to fund community health centers by filling in the appropriate blank on their state income tax forms. S.B. 1305 was sponsored by Rep. Donne E. Trotter (D-Chicago), and by a large group in the Senate led by Sen. Penny Severns (D-Decatur).

Three other bills killed

Three bills besides H.B. 1303 had received total vetoes from the governor; none of the vetoes was overridden.

S.B. 1302, the Allied Health Care Professional Assistance Act, would have established an IDPH program for grants and scholarships to allied health care professionals agreeing to practice in designated shortage areas, one year for each year of credit. The bill was sponsored by Rep. Trotter and Sen. Rea.

S.B. 1306, the Rural Health Care Services Improvement Act, would have allowed counties to form regions to provide rural ambulance services under the supervision of rural ambulance system advisory boards, and would have authorized IDPH to issue grants to assist counties in providing regional ambulance service. S.B. 1306 was sponsored by Reps. Phelps and Woolard, and by Sen. Rea.

S.B. 1307 would have authorized IDPH to develop and operate a nursing education pilot grant program to pay student loans for nurses who agree to work in underserved areas. The bill was sponsored by Reps. Trotter and Woolard, and by Sen. Miquel del Valle (D-Chicago).

Bills hit governor's desk

In addition, H.B. 168 was passed by legislature and now awaits the governor's signature. This Illinois Agriculture Association/ISMS-sponsored legislation would permit liquidated damages in agreements between private organizations and students for loans or grants for medical education. It was sponsored by Rep. Homer and Sen. Demuzio.

And S.B. 1304, which became caught up in parliamentary maneuvering, awaits action by the governor. 1304 would have approved an IDPH pilot program to award one-time stipends to newly graduated nurses and nurses who relocate to underserved counties. The governor's amendatory veto mandated examination of other state and private sector programs before approving a specific stipend and an IDPH structure for application procedures and criteria. The bill was sponsored by Rep. Phelps and Sen. Rea. ▲

1990 ISMS TEAM PHYSICIAN AWARD

Request for Nominations

The Illinois State Medical Society is now accepting nominations for its 1990 Team Physician Award.

Since 1983, the Team Physician Award has honored physicians who have volunteered their time for 10 or more years at the high school or college level to assist young athletes, their coaches, schools and communities with injuries, nutrition, and physicals related to team sports.

Only ISMS members are eligible to receive the award.

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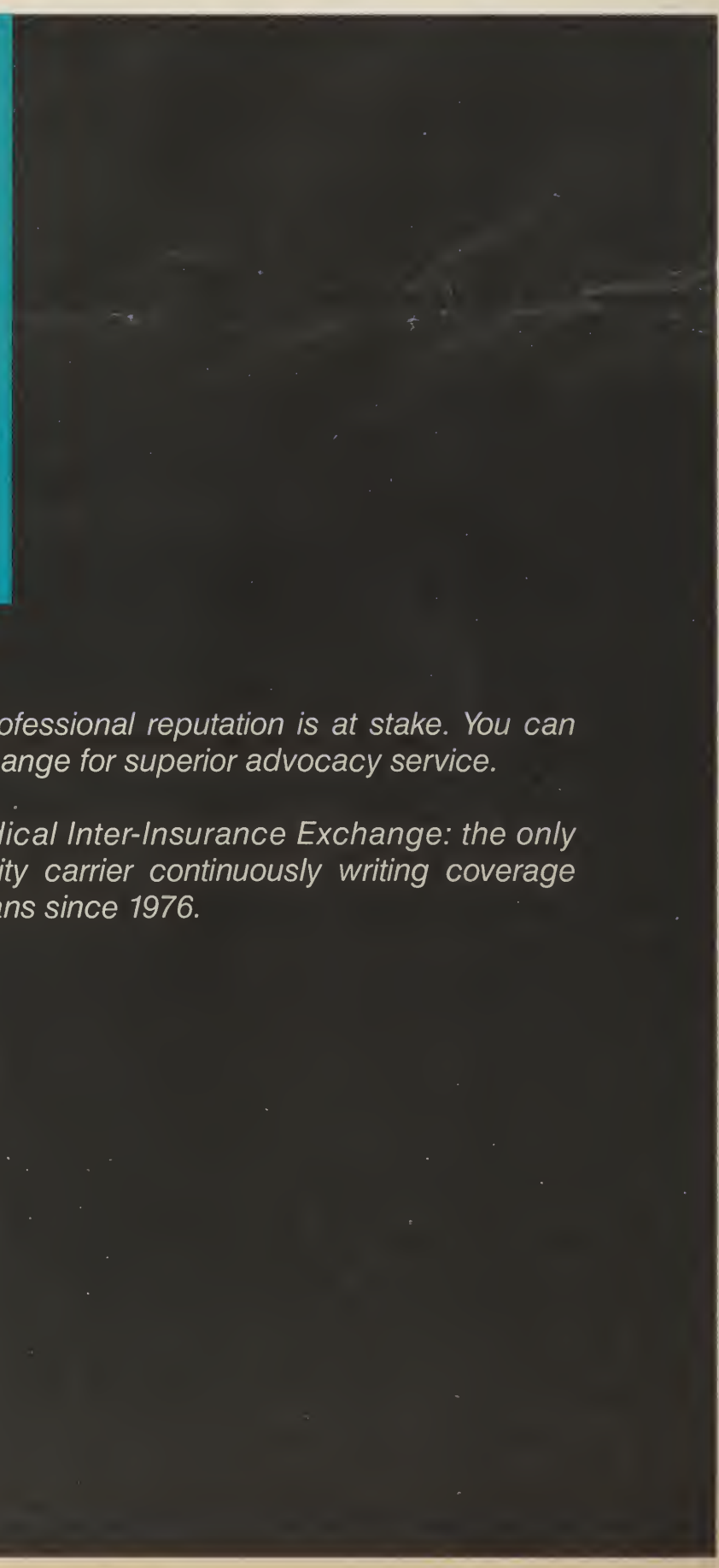
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Illinois Medicine

November 24, 1989

ILLINOIS STATE MEDICAL SOCIETY

State high court rules on terminally ill

THE ILLINOIS SUPREME Court ruled November 13 that food and water can be withdrawn from terminally ill patients under certain highly controlled circumstances.

The high court, in a 4-2 vote, decided in *In re Estate of Longeway*, that relatives of a terminally ill individual can request the withdrawal of nutrition and hydration after the patient is diagnosed as irreversibly comatose or in a persistently vegetative state, and the diagnosis is confirmed by three physicians, including the patient's. In this ruling, Illinois joined more than 20 states which have ruled on the issue of respirator maintenance or nutrition/hydration.

The high court's ruling poses a number of challenges to physicians and families of the irreversibly ill.

"I think the first thing doctors need to understand," said Saul Morse, Illinois State Medical Society (ISMS) general counsel, "is that if the patient has executed a living will or a durable power of attorney, this opinion will not impact that patient. If the patient has not executed one of those documents, and the next of kin or guardian wishes to withdraw nutrition and hydration, a petition will have to be filed in court, and the five parts of the supreme court's test will have to be met."

In the test, the petitioner must first prove the patient is terminally ill. Second, the patient must be diagnosed as "irreversibly comatose or in a persistently vegetative state." Third, the state has a right to determine whether any state interests outweigh the petitioner's. Those could include preserving the ethical integrity of the medical profession, preserving life, avoiding suicide, and avoiding injury to third parties.

Fourth, the court ruled that moral tests, such as the "substituted judgment" test, must be weighed. Under that test, a court attempts to apply the judgment the patient might have used were he able.

Finally, the court determined that judicial scrutiny is appropriate where there is a question of the patient's desires. "Clear and convincing evidence" is the standard, one which Morse calls "fairly high. In most civil litigation," he notes, "you need only a preponderance of the evidence. That is what is new about this decision."

Practicing physicians and ethicists differed in their reactions to the ruling. "I think it's a step forward," said David Littman, M.D., an ISMS trus-

(continued on page 14)



Tuscola Review/David Porter

Jack Allen, (L) Tuscola County Clerk, and Helen Zeigler, County Treasurer, count ballots following a referendum to raise taxes to support the hospital. The proposal failed. (Story on page 13.)

Illinois deletes two generics; FDA head reassigned

THE TWO AVAILABLE generic substitutes for the drug hydrochlorothiazide/triamterene have been deleted from the Illinois formulary which regulates substitutions in Illinois. The Illinois Department of Public Health (IDPH) action was the first of its kind in the state since generic substitutes came under scrutiny in the summer of 1989.

The companies involved, Bolar and Vitarine, manufacture substitutes for the single available commercial brand, Dyazide, produced by Smith Kline & French. Dyazide is prescribed as an antihypertensive.

Vitarine voluntarily pulled its generic from the market, while Bolar's generic was deleted from the for-

(continued on page 14)

ISMS presses AMA to investigate finance irregularities; asks AMA to 'redefine mission.'

ILLINOIS delegates attending the American Medical Association's December policy meeting will sponsor a resolution asking for full investigation of the AMA's "current financial practices relating to investments, pension funds and other AMA financial matters."

Approved by the Illinois State Medical Society's (ISMS) full board of trustees November 17, the resolution responds to a top AMA staff executive's admissions that he received an "inappropriate" $353,000 payback of personal pension assets lost in the October 1987 stock market crash. Whalen Strobhar, president of American Medical Services, Inc., the AMA's holding company for its for-profit subsidiaries, resigned October 26, and agreed to repay the money.

The ISMS resolution says AMA should retain independent legal counsel to review the situation. AMA has already hired the Chicago law firm of Jenner and Block to do so.

The ISMS resolution also asks for "an independent outside consultant to review the administrative structure and managerial process of the AMA." James H. Sammons, M.D., AMA executive vice president who approved the repayment to Strobhar two years ago, said he based that decision on what he perceived at the time as an AMA error in transferring the funds. He reversed the decision after a recent internal investigation and inquiries by the Chicago *Sun Times*.

The ISMS resolution also calls on AMA "to redefine its mission statement . . . to provide the best possible representation of members and representation of the profession at the national level, and develop an analysis of the diversified AMA activities and holdings to assure these serve the members' needs." In addition, it recommends that the AMA board "conduct an in depth review" of the organization's various policymaking functions, and how they inter-relate.

Illinois delegates have forwarded the resolution for distribution to the AMA's full House of Delegates. The 435 member AMA House has several action options: it can accept, reject, amend, or refer the resolution to the AMA board. The Illinois State Medical Society represents 18,000 physicians statewide. ▲

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Initial optimism fades amid political dissension

Cook County health care summit gets underway

by Kevin O'Brien

ON NOVEMBER 3, the Chicago and Cook County Health Care Summit convened at Chicago's Hyatt Regency Hotel to attack the critical problems of health care delivery to the county's poor. Meeting together as members of the summit's two working committees—the policy steering committee and the system design and management committee—were leaders from the worlds of public health and politics, medicine and social services, business and labor, academia and professional associations.

The summit had been hailed by top government leaders as a rare exercise in inter-governmental cooperation, and announced with great fanfare by Governor James R. Thompson, Chicago Mayor Richard M. Daley and Cook County Board President George Dunne in August.

But the meeting was barely two hours old when cracks in the facade of unity began to appear. After hearing pleas for help from three people who deal daily with the problems of inadequate care, members of Dunne's County Board interrupted to complain pointedly about a summit planning process that had excluded them, and presumably, Dunne. Others charged that the composition of the summit's two committees did not adequately represent the constituencies served by the public health agencies whose operations the summit would review.



Wm Daniels/The Photo Partners

Cook County Commissioner John Stroger, who criticized the summit planning process at its Nov. 3 meeting.

Consequently, a carefully planned effort to instill in summit participants a note of optimism was thwarted. Instead, Illinois Department of Public Health Director (IDPH) Bernard Turnock, M.D., Chicago Board of Health President Whitney Addington, M.D., and Chicago Acting Health Commissioner Richard Krieg, Ph.D., found themselves defending a committee appointment process they each contended had been taken out of their hands.

Although County Board Commissioner John Stroger readily acknowledged that even "Ray Charles and Stevie Wonder both could see that we need a new county hospital," he also criticized Dr. Krieg's exclusion of county financial people among summit staff positions, saying that "No matter how you look at this, the city has a very insignificant role in the county health care system."

Summit member Gloria Jackson Bacon, M.D., observed, "as I hear the squabbling going on in terms of territory, my comment was that possibly this whole summit will self-destruct on a territorial basis." Nevertheless, she also questioned the summit's committee composition. Noting the absence of black physicians and community leaders, she said, "I don't think that this group as assembled represents, or is representative of, the people to be served."

As now structured, the summit is comprised of two committees. The larger 39-member policy steering committee, chaired by Dr. Turnock, is charged with developing overall principles to guide formulation of the coordinated plan. A 10-member system design and management committee, under Dr. Krieg's leadership, will devise specific recommendations that will constitute the plan.

The Illinois State Medical Society (ISMS) is represented on the policy steering committee by ISMS Board Chairman Harold L. Jensen, M.D., while ISMS Executive Vice President Alexander R. Lerner sits on the system design and management committee. Chicago Medical Society President Ulrich F. Danckers, M.D., is also a member of the policy steering committee.

(continued on page 13)

Abortion: Illinois settlement talks gain momentum

by Kevin O'Brien

AS *ILLINOIS MEDICINE* was going to press, persistent but unconfirmed reports surfaced of an imminent settlement of the controversial *Turnock v. Ragsdale* abortion case.

Despite efforts of several pro-life groups to halt or frustrate them, attorneys for the state and Rockford physician Richard Ragsdale, M.D., were engaged in marathon settlement negotiations.

Turnock v. Ragsdale pits Illinois Department of Public Health (IDPH) efforts to apply regulations governing ambulatory surgical treatment centers (ASTCs) to abortion clinics against Dr. Ragsdale's claim that compliance is prohibitively expensive for most clinics, and thus would deny most poor women their constitutional right to an abortion.

Supporters of Dr. Ragsdale broached the idea of a settement in August, but the idea was immediately condemned by pro-life groups. Pro-choice advocates are concerned that the case is an ideal vehicle for the U.S. Supreme Court to overturn the landmark 1973 *Roe v. Wade* ruling legalizing abortion. Pro-life advocates believe the same thing, and want the case to reach the high court.

The case is scheduled to be heard by the Supreme Court on Dec. 5; settlement talks began Oct. 16. Attorney General Neil Hartigan, whose office is representing IDPH, has said he needs to notify the Supreme Court if a settlement is imminent and the high court's oral arguments need to be delayed.

Any agreement the parties reach would require the approval of U.S. District Court Judge John A. Nordberg. If the judge disapproves the agreement, oral arguments in the Supreme Court could be rescheduled. Four years ago, Judge Nordberg enjoined IDPH from enforcing the regulations against physicians who perform first or early trimester abortions in private facilities. The ruling was sustained by the U.S. Court of Appeals on March 10, 1988.

On Nov. 8, Judge Nordberg denied a motion of downstate Madison County State's Attorney William R. Haine to substitute himself in the negotiations for Cook County State's Attorney Cecil Partee. Partee succeeded former State's Attorney Richard M. Daley, now mayor of Chicago, as attorney in the case on behalf of all Illinois state's attorneys as a class.

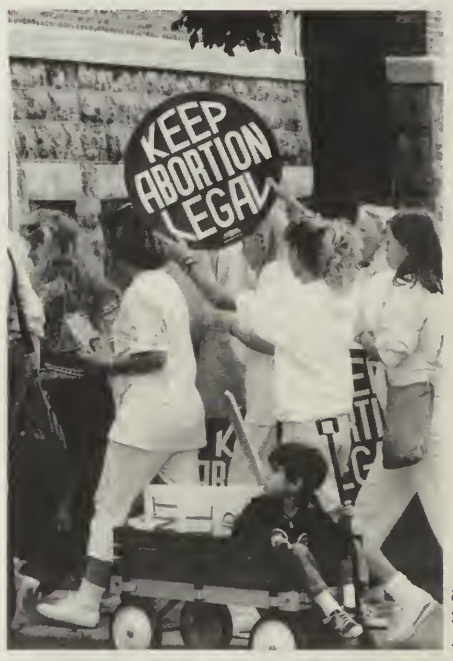
When the appeal was filed, all parties agreed that Hartigan's office would argue the case on appeal. Haine contended that because Partee has not been an active participant in the settlement negotiations, the interests of Illinois state's attorneys have not been adequately represented.

Haine's motion was argued by James Bopp, Jr. of Terre Haute, Ind., general counsel for the National Right to Life Committee. Granting Haine's motion would have resulted in active pro-life advocates becoming party to the settlement negotiations. Lawyers with the American Civil Liberties Union (ACLU) represent Dr. Ragsdale.

Judge Nordberg, in denying Haine's motion, said the "Decision [of the Cook County state's attorney] not to join in the appeal was well considered and made sense to avoid duplication and save taxpayers money."

After the National Right to Life Committee failed in its attempt to join the settlement talks, the Illinois Right to Life Committee was joined by 12 other national and state pro-life organizations in calling a press conference on Nov. 13 to demand that Hartigan withdraw from the case. Failing that, they called on Gov. Thompson to appoint another attorney in his place.

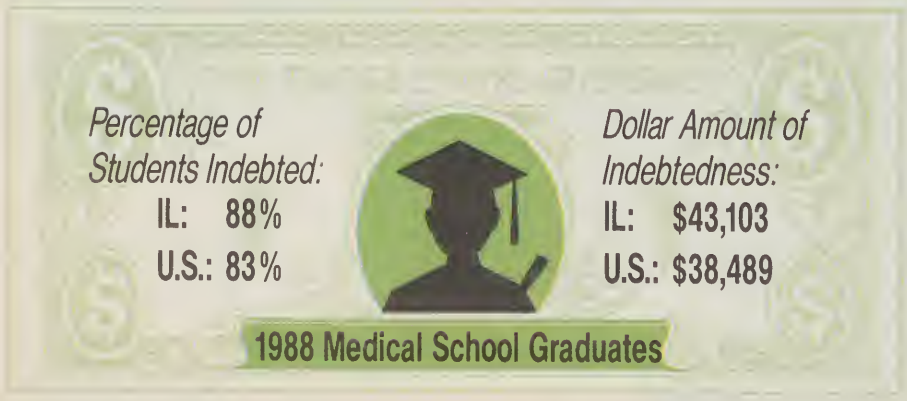
"For [Hartigan] to contrive to rewrite the statutes in 11th hour dealings behind closed doors with the ACLU," said Illinois Right to Life President Mary Anne Hackett, "compromises the office of attorney general and perverts the will of the people as expressed through their elected representatives." ▲



Jon McGinty

Pro-choice advocates picket the offices of plaintiff Richard Ragsdale, MD, in Rockford.

Physician Facts



Figures represent the mean.

Source of Data: Association of American Medical Colleges

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Hospitals call ICARE increases "step in the right direction"

by Franklin J. Kourt

THE RATE OF reimbursement to Illinois hospitals through the Department of Public Aid's Illinois competitive reimbursement equity program (ICARE) has increased this year. Chicago area hospitals view the jump as a positive step toward recovering their costs.

The state recently negotiated ICARE contracts with Chicago area hospitals, and will continue with hospitals throughout the state over the next several months. These contracts allot an annual number of Medicaid inpatient days to each hospital, and determine the daily rate paid.

Because the contracts are competitive and negotiated on a hospital-by-hospital basis, the rates each institution receives are confidential until negotiations are completed for the entire state, according to Robert Wright, deputy administrator of medical programs for the Department of Public Aid.

"The department doesn't want to make even a general statement about what happened to rates in the City of Chicago," Wright said, but added that it would be fair to say rates increased "significantly."

Disproportionate share payments

Wright also discussed disproportionate share payments, which provide a larger reimbursement rate for hospitals with a disproportionate share of Medicaid patients. He said 50 Illinois hospitals will qualify for disproportionate share during the 1990 fiscal year, the majority of which are located in the metropolitan Chicago area. He said that during fiscal year 1989, the state allocated the department $5 million for disproportionate share, a figure that jumped to $60 million this fiscal year (1990). Also this year the criteria that allow hospitals to qualify as disproportionate share hospitals were expanded.

"Not only do more hospitals qualify than otherwise would have, but payments are much higher and I think that's important," said Wright, adding that this year the state is negotiating two-year contracts with hospitals for ICARE funds.

He said that while some hospitals will see improved financial conditions as the result of new ICARE rates, he does not believe Medicaid rates alone make the difference on whether a hospital will close.

Wright said all Chicago hospitals that sought an ICARE contract received one. All but four sought one, and two of those were part of or affiliated with other hospitals who were in on negotiations.

Alfred Clementi, M.D., a member of the Hospital Services Procurement Advisory Board, which oversees ICARE activities, said the increase is "certainly appreciated," noting that the group has very little to do with price-setting and acts only in an advisory capacity.

Hospitals comment

Hospital officials polled all expressed appreciation with the increases, calling them a step in the right direction, but pointing out that despite those increases, the new rates do not cover the full cost of caring for Medicaid patients.

"Obviously we're pleased with the results of the effort put forth by the Department of Public Aid to bring rates more in line to the cost of treating these patients," said Chuck Weis, vice-president of finance at Chicago's Mount Sinai Hospital. "From our budgeting standpoint, we are a lot closer to breaking even than we could have been, so it has helped us financially. It's still very tough to make it with the kind of public aid volume we see." Mount Sinai Hospital, noted Weis, is an institution with 42 percent of patients on Medicaid, and one which qualified for higher funding as a disproportionate share hospital.

Mike Koetting, vice-president for program evaluation at the University of Chicago Hospitals, where the amount of Medicaid business is about 30 percent—also qualifying for disproportionate share—called the rate increases "a big improvement."

Like his Mount Sinai counterpart, however, Koetting said the increase still does not reimburse the hospital the full cost of Medicaid patient care. He said the new rates reimburse his hospital for "under 75 percent" of the total cost, where previously it was under 60 percent.

Diane Benjamin, public relations director at Loretto Hospital, which also has a disproportionate share of Medicaid patients, said the hospital is "grateful" and called the new rates "the first glimmer of hope in a long time."

She explained that Loretto took a strong proactive role in campaigning for ICARE rate increases, lobbying state representatives in Springfield, hosting meetings called by officials to consider such legislation and testifying at state capitol hearings. ▲

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REPORT FOR *Illinois Physicians*

BLUE CROSS AND BLUE SHIELD OF ILLINOIS ANNOUNCES EXTENDED MENTAL HEALTH PROGRAM

Blue Cross and Blue Shield of Illinois (BCBSI) will be offering a new subscriber benefit effective January 1, 1990 termed the 'Extended Mental Health Program'. This benefit will be offered to employers which select this benefit option and the BCBSI Million Max business in the Chicago metropolitan area. The Million Max Program can generally be defined as small group business with ten to one hundred employees. Extended Mental Health benefits will be in addition to the current mental health and substance abuse benefits, which benefit levels are determined by the employer group.

Extended Mental Health providers will be those meeting the BCBSI Terms and Conditions and which contract specifically to provide such Extended Mental Health Services.

If you are interested in participating, copies of the BCBSI Terms and Conditions for the Extended Mental Health Program are available by writing to Greg Mace, Manager, Hospital and Professional Affairs, Blue Cross and Blue Shield of Illinois, 233 N. Michigan Avenue, Chicago, Illinois 60601.

(This report is a service to the physicians of Illinois)
11/24/89

Editorials

Life-prolonging measures and patient autonomy

The Illinois Supreme Court's November 13 ruling, complex as some of its provisions are, moves us a step forward in clarifying the legal status of patients and physicians in a critical decisionmaking process—that of determining whether to continue artificial nutrition and hydration when a patient's life can no longer be sustained without those measures.

But the ruling also injects another legal hurdle into the physician-patient relationship, one which could require court appearances, attorney consultations, and further intrusion into the care of patients in persistent coma or terminal illness.

There is an alternative to the elaborate procedures outlined in the court's ruling. Patients who execute advance directives (a Living will and/or durable power of attorney for health care) can clearly state their wishes regarding life-prolonging treatment, leaving open no conflict for courts to resolve.

Doctors can help their patients and avoid legal bureaucracy by educating themselves, their patients and family members about these tools. Such education can help to reduce the chances of patients' families having to appear in court at the most agonizing of moments. ▲

Health care summit: proceed with care

The Chicago and Cook County health care summit got underway November 3. It is a good example of the challenges that face government leaders and health care providers in Illinois.

On the one hand, the summit gathered together distinguished leaders from a broad spectrum of fields, people who know what's going on in Cook County and who have the ability to do something about it. On the other hand, political dissension surfaced almost immediately, as politicians got caught up in territorial and other non-policy issues.

That dissension injected a dose of realism into the affair. But beyond this sideline event, real issues exist that will provide authentic material for discussion and debate. It will be tempting for the summit to consider ostensibly "easy" answers to complex problems; but there are no simple, inexpensive solutions to caring for medical needs of the poor. Monumental problems remain; the situation may demand decisions that are not politically expedient.

The Illinois State Medical Society, as a summit participant, pledges to do our best to help find workable solutions for the poor, who need access to quality health care. Summit leaders have the chance to make real inroads. Let's see to it that chance isn't wasted. ▲

Illinois Medicine

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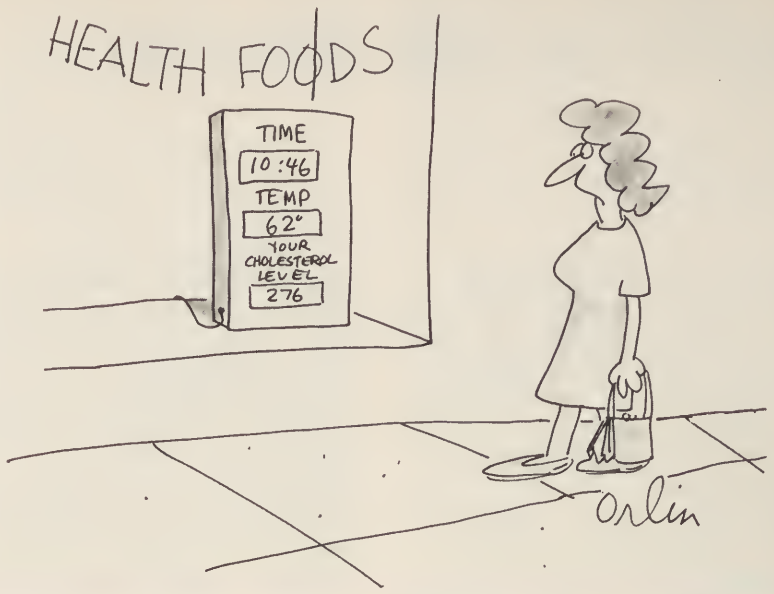
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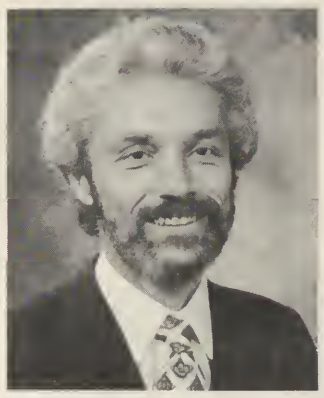
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Guest Editorial

Patient care and profit: a question of service



by Robert E. Becker, M.D.

A disturbing trend is developing in American medicine. Years ago, physicians never considered profit a guiding principle in the decision of whether to prescribe medical services to patients. In recent years, however, financial incentives have cropped up which have tempted some MDs to do just that. Some of the financially beneficial strategies are more benign than others.

One of the more recent developments, that of physicians investing in the medical services used by their patients, can provide those physicians with the opportunity to profit financially from the costs of hospitalization, laboratory testing, imaging studies or other prescribed procedures.

Although there have always been physicians who have made such investments, it appears this practice is becoming more widespread. Still, many doctors refuse to involve themselves in such investments, viewing them as an unethical conflict of interest. Their reasoning is straightforward.

There is too much temptation today, in an era of tight health care costs, to prescribe unnecessary diagnostic procedures, care or treatment in order to gain the sometimes-considerable financial rewards available. The consequences of these temptations are supported by the Inspector General's report to Congress, which finds that patients are prescribed 45 percent more clinical laboratory services at physician-owned laboratories than are Medicare patients in general. Conversely, when a physician is aware of this potential for abuse, he may not ask for needed tests, in order to avoid any appearance of conflict of interest.

In either case, the patient suffers, the quality of care is reduced, the credibility of the medical profession is compromised, and the call for outside regulation of medical practice is reinforced.

The art of medical practice is based on a centuries-old tradition of service to patients. Medicine is a discipline, and we discipline ourselves to apply our training to care of the ill. I believe the high levels of physician respect reported in public opinion polls represent the public's awareness that our profession rejects the temptation of self-reward in favor of the privilege of healing the sick.

The patient who expects to pay for physician services is appropriately disturbed to find that his physician has personal financial gain or loss to consider in deciding the prescription for diagnostic studies and treatment. This directly counters an important tradition of medicine: that the primary and only physician concern is providing the best care for the individual patient. I do not know how a physician can maintain this focus when the outcome from a medical judgment affects personal income.

In short, patients are not well-served when a physician's attention is distracted from patient care. Our profession finds itself in a time of ethical crisis. The question is, will we rally to preserve our heritage as a learned profession? Will we discipline ourselves, or be disciplined by Congress? This time of ethical crisis is both collective and individual. If the leaders of our state and national medical organizations do not act to preserve our heritage, we will be diminished, and our heritage will be legislated. ▲

Dr. Becker is a professor, and chairman of the department of psychiatry at Southern Illinois University School of Medicine in Springfield.

Guest Editorial

The Lake County experience and the "culture of medicine"



by Michael L. Millenson

For two days, nine of us from the community spent half-day shifts with physicians as part of an innovative "mini-internship" program sponsored by the Lake County Medical Society (see story on page 8). A couple of reporters, a police chief, attorney, a corporate benefits manager and others pierced the veil of medical secrecy to see first-hand how internists, ophthalmologists, urologists, radiologists and a bunch of other *-ists* went about their jobs.

Now, after two long days, our diverse group agreed on one burning question for the doctors gathered to discuss the program with us: "When do you people eat, anyway?"

Actually, that may have been one of the tougher questions we asked. Mostly, our north suburban Chicago version of "48 Hours" (*pace,* Dan Rather) left us admiring the doctors for how hard they worked.

More importantly, we all were impressed by the multitude of tough decisions, one after another, our doctors had to make all day long, often based on just a few pieces of objective information.

As a reporter on the national staff of the *Chicago Tribune,* I jumped at the chance to participate in this first internship program in Illinois when I was told about it by George Goldstein, M.D., the society's president. Since I began covering health care policy issues in 1982, I've listened to many doctors complain that outsiders don't understand the demands of their profession. Unfortunately, though, ordinary practicing physicians are among the toughest people in the world to get an interview with.

The strength of the Lake County program was that it offered laypeople a chance to immerse themselves in the culture of medicine. We could simply watch what a doctor does and talk to him or her about it without there being a preset agenda.

So what did I learn? I had done something similar before, during a year-long leave of absence I was reminded of the complexity of medical decision-making and the intricate web of relationships binding doctors to each other and hospitals.

I also reminded myself how utterly dependent patients are on doctors. I am more knowledgeable than the average patient, but how can I judge the radiologist I never meet? What do I know of the strengths of different emergency rooms or which nursing staffs are strongest? In the end, I still must place my trust in a primary care doctor.

What should I look for? James Monahan, M.D., an internist and cardiologist I followed on his rounds at Waukegan's Victory Memorial Hospital, summed things up the best. He said, "Ability and character are what count in the doctor business."

Ability. How does a layman judge that? I asked patients of the internist and orthopedist I followed how they had chosen them. A lot of referrals from nurses popped up—always an excellent indicator.

Character? If it means traits like compassion, honesty and steadiness under pressure, I think laypeople can judge that well.

Of course, the doctors who participated in this program were both self-selected and peer-reviewed. The HMO doctor who didn't call me back to authorize my going to the emergency room when I first cut my finger wasn't on this program. Neither were the guys who have their wives call them "Doctor," nor the out-and-out incompetents whose faults the good doctors all too often ignore.

The doctors in Lake County are lucky. Their medical society took a chance and treated us interns as partners. The payoff was that some influential citizens went away with real admiration for the "silent majority" of physicians, while the doctors got the rare chance to hear what an educated layperson thinks they are doing right and wrong.

What a change from attitude of "We talk, you listen," that is all too common among the politician-type doctors who lead so many medical groups. I hope other physicians will show the ability and character to try out this prescription themselves. ▲

Michael Millenson is a Chicago Tribune *financial writer specializing in health care policy issues.*

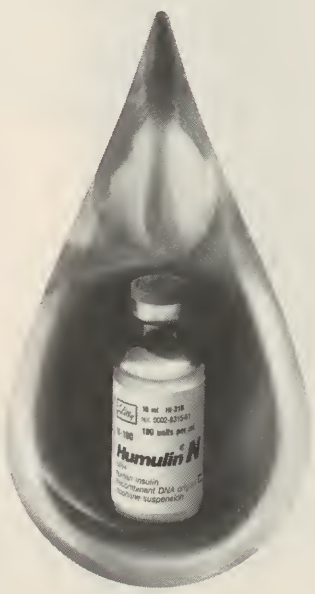
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Case in Point

by Carol Brierly Golin
President, Medit Associates

Office staff telephone advice can be a "wrong number"

Case in Point departs from its usual format to explore liability that can accrue to a physician as a result of office staff response to phone calls.

Could this happen in your office?

Case #1

The case in brief—A new patient telephoned a family practitioner on a Friday morning to request an appointment. She told the registered nurse that she was experiencing severe stomach pains. The nurse asked the woman, a 27-year old mother of two, several questions, including, "Where is the pain located? When did you last have a period? Do you have any vaginal bleeding? Could you be pregnant?" The woman said she did not think she was pregnant and repeated that the pain was in her stomach area. The nurse told the patient the physician could not see her until Monday and booked an appointment. The nurse advised the woman to go to bed and apply heat to the painful area. On Sunday, the woman's husband found her dead in her bed. The cause of death was a ruptured ectopic pregnancy.

The resulting claim—The woman's husband and children filed suit against the physician and the office nurse, alleging failure to diagnose and delay in treatment which resulted in a wrongful death.

The outcome of the claim—The case was settled for an amount exceeding $1 million.

Case #2

The case in brief—A woman telephoned her pediatrician's office to report that her three-month old son was ill with congestion, an elevated temperature, and was up most of the night crying but refusing to take his bottle. She asked if she should bring the baby in to see the doctor. The receptionist, who had been fielding a succession of calls from mothers whose children had similar symptoms, said, "I wouldn't worry about it if I were you. There's a lot of flu going around. The doctor has been telling all the mothers to give baby aspirin to keep the fever down and to push fluids." No message was relayed to the doctor. Two days later, the mother called to report that the baby's temperature was 102 degrees and that the child was extremely ill. This call was put through to the physician who immediately hospitalized the child and diagnosed spinal meningitis. The child recovered but suffered brain damage and deafness.

The resulting claim—The parents sued the pediatrician for delay in diagnosing and treating meningitis which resulted in brain damage and deafness.

The outcome of the claim—An undisclosed structured settlement was negotiated on behalf of the child.

The points these cases make—In each instance, the physician's employee delayed the rendering of appropriate treatment, either by implying a diagnosis, suggesting treatment, or making an improper judgment about the seriousness of the problem. These employees decided when a patient should be seen by the doctor and whether the patient could talk directly to him/her.

—In the first case, the office nurse gave medical advice and also established a doctor-patient relationship by booking an appointment, when the physician had never seen or talked to the caller. The best course of action would have been to refer the caller to the physician who would have decided whether to see her in the office or refer her to an emergency room. If the physician was not readily available, a complaint this serious from a "new" patient should have been referred to another physician or to the nearest emergency room.

—In the second case, the physician's employee suggested a diagnosis and a treatment for the infant's problem. She assured the mother that the problem was not serious. There was also a failure to record the first call and to relay the information to the pediatrician for a call-back, rationalizing that, "If the problem is serious, she will call again."

Physicians can be sued for the actions of their employees because they act as extensions of the physician and work under his/her direction. In many situations, the failure to train employees adequately and provide guidance and supervision to them forces the employees to use their own judgment to deal with day-to-day office situations. This sets the stage for well meaning employees to create potential patient injury, and unnecessary liability involving themselves and the physician.

On the other hand, a well-trained staff operating with proper guidelines can be an important defense

(continued on page 7)

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

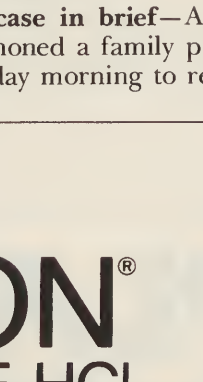
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Exchange Q&A

Physicians are encouraged to submit queries to: Exchange Q & A, Illinois Medicine, *Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.*

Q: *Does ISMIE make available any educational materials on the litigation process?*

A: Yes, the Exchange offers many services to prepare physicians to deal with litigation. Educational materials ranging from brochures and videotapes outlining the various stages of the process, to personal support programs dealing with the stress of being sued are available. If a policy holder is sued, a professional liability analyst is assigned to the claim. The analyst, defense attorney, and defendant physician work as a team that fully involves and supports the physician throughout the process. Physicians who have gone through the lawsuit experience are available through ISMIE's physician support group to offer support to colleagues who have been sued and their spouses. Contact an ISMIE professional liability analyst or the risk management department at (312) 782-2749, or toll free at 1-800-ISMS, to obtain a list of available materials. ▲

against professional liability claims for the physician. They can do this by efficiently and courteously carrying out office procedures, and by being aware of and alerting the physician to potential patient dissatisfaction, and other problems that could result in liability, so action can be taken to resolve the problem.

Drawing from the cases described, ISMIE risk management offers these suggestions for avoiding similar liability problems when handling phone calls in the office setting:

—Qualified personnel should be hired and trained to perform the duties required by the physician employer.

—Written job descriptions should define the duties of each employee and should be compatible with training, experience and applicable licensure/certification.

—Written procedures should guide office practices, including handling phone calls and scheduling appointments. Employees should be cautioned against any action that would imply giving medical advice or diagnosis, suggesting treatment, or offering guarantees in the form of promises or assurances.

—Procedures should define those calls the employee is authorized to handle and provide guidelines for identifying calls that should be referred to the physician on a routine and urgent basis.

—A record of phone calls should be filed with the patient's records, describing at minimum, who called, the complaint, instructions given, and the date and time of the call.

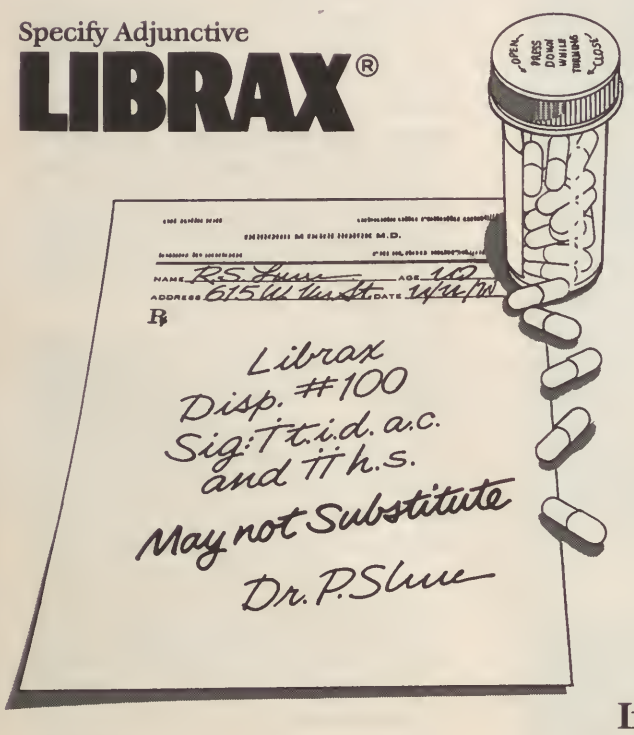
—A record of all calls handled by the staff should be reviewed daily by the physician with attention to any calls that require additional follow-up by the physician or staff. If a problem such as those represented by the claims examples occurs, this system would recognize the problem promptly and hopefully avoid a similar outcome.

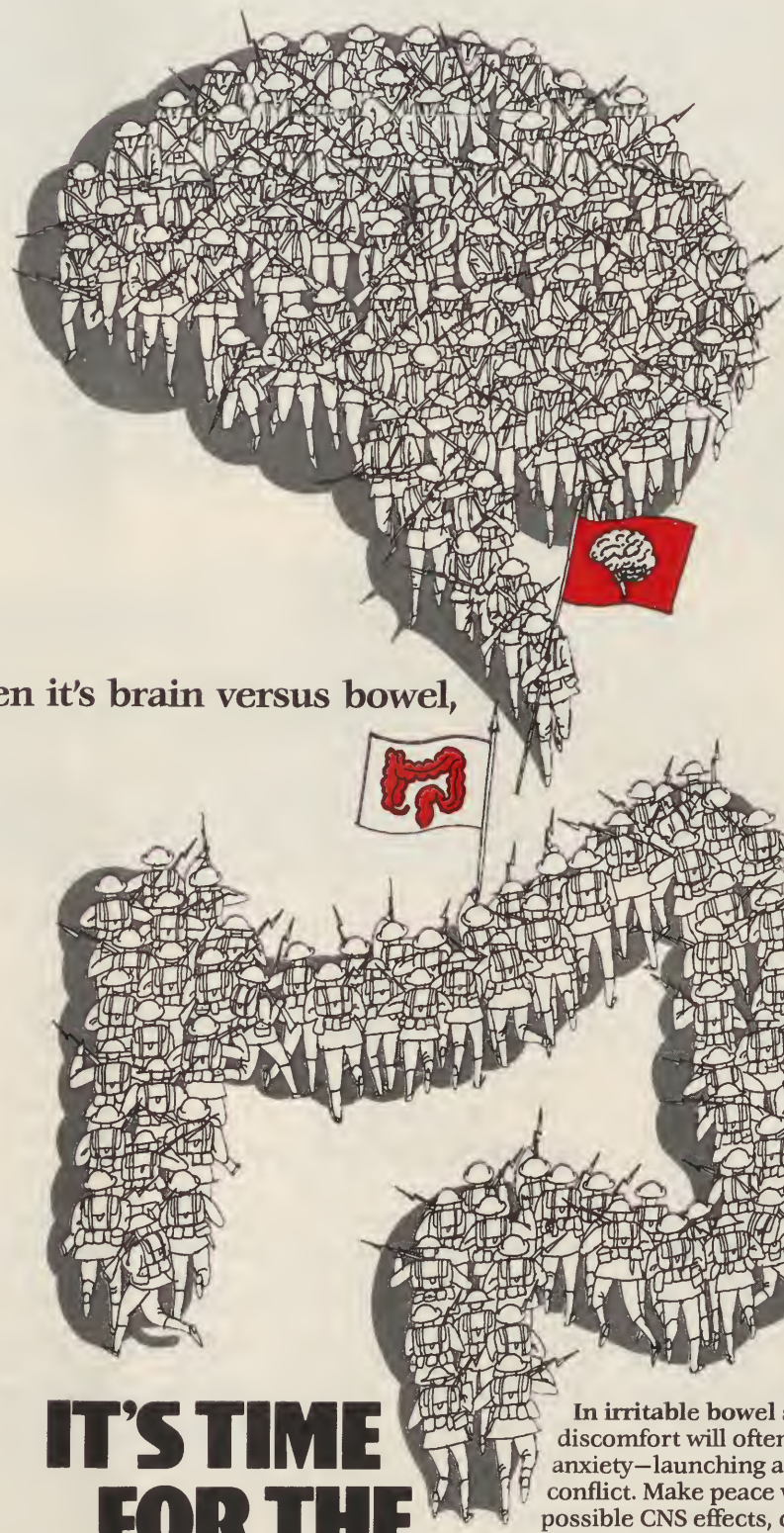
—Some flexibility for scheduling urgent appointments should be maintained. Trying to juggle an impossible schedule may pressure employees to schedule inappropriately a patient who should be seen the day they call.

—The handling of phone calls by the staff and the phone system should be evaluated periodically. This can be done through patient interviews, questionnaires or by questioning others who have frequent contact with your office for their honest opinion of how efficiently and courteously their calls are handled.

Remember that it is the physician's responsibility to train and provide guidelines to office staff. Serious problems, such as the cases described, can occur when well-intentioned, but inadequately trained staff work beyond their training and authorization and become a barrier between the patient and the physician. ▲

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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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Lake County mini-internship program yields a wealth of benefits

by Vicki Gerson

THE LAKE COUNTY Medical Society's (LCMS) mini-internship program is exposing the human side of medicine to a wide variety of business, political, media, labor, clergy, education and health care leaders. The program, launched September 24-25, is the first of its kind in Illinois, and has been hailed as providing a unique opportunity to enlighten non-physicians about the contemporary practice of medicine. (See also Michael Millenson's guest editorial on page five of this issue.)

"Our mini-internship program," explains James P. Monahan, M.D., chair of the LCMS community relations committee, "has been modeled after the highly successful five-year-old program at the Academy of Medicine of Cincinnati. In today's health care environment of spiraling costs, confusion, criticism, litigation and misunderstanding, LCMS feels health care professionals must respond to medical consumers' concerns by establishing ongoing and open communications."

The physicians participating in this two-day community outreach program, Dr. Monahan says, represented a broad spectrum of medical specialties, including family practice, internal medicine, surgery, neurology, and obstetrics/gynecology.



Chip Zellet

Mini-intern Darla Gryb (right) looks on as participating physician Thomas Glimp, M.D., performs surgery.

Structuring the program

Nine mini-interns were selected for the program, while physicians from all five Lake County hospitals were asked to participate. Interns and participating physicians were invited to the September 24 orientation dinner, at which time each intern received a two-day timetable scheduling him/her to meet with four different physicians in a hospital or office setting for a brief exposure to his/her specialty. The program concluded with a debriefing dinner during which interns told what they learned about the medical field.

Participating interns agreed to maintain a respect for patient confidentiality, stay on schedule, and contribute to the evaluation process during debriefing. Patients kept the right to refuse to have an intern present.

When LCMS decided that a mini-internship program would be beneficial to its 561 members and to the community, it clarified four main goals:

- to show the human concerns of physicians through the first-hand exposure of those who influence or report on health care policy;
- to demonstrate physician interest in containing health care costs and commitment to upholding quality patient care;
- to open lines of communication with the community;
- to promote self-examination among physicians working in today's costly bureaucratic tangle.

According to Jane Stein, LCMS executive director, the special effort put forth by participating physicians was a key ingredient in the program's success. She cited, for example, Mohammed Siddique, M.D., the LCMS 1990 treasurer, who felt it was an important experience for his intern, Mark Wiemer (employee relations manager for Cherry Electrical Products) to watch the utilization review committee of St. Therese Hospital in action.

"Because Dr. Siddique, chairman of this committee, believed his intern should know that physicians and hospitals get together to critique the performance of their physicians and the hospital," says Stein, "he took it upon himself to write an individual note to each physician on the utilization review board about the value of having an observer. In order to convince committee members they wouldn't be revealing any confidential facts about a specific physician," she continues, "Dr. Siddique suggested that they change the names of the physicians under review. Therefore, he overcame obstacles and made the mini-internship program worthwhile for that individual."

And what did physicians learn?

Mini-interns weren't the only ones who accrued benefit from the program. Participating physicians like David A. Fetter, M.D., an orthopedic specialist, came away delighted that they, too, had learned some things as a result of the encounter. "Suddenly," says Dr. Fetter, "I realized that although I was teaching my mini-intern, I was also teaching my patient. Furthermore," he says, "it's important to really listen to the questions being asked so that you can answer them correctly."

Dr. Fetter, who was meeting with Darla Gryb, executive director of the American Heart Association in Lake County, says he and Ms. Gryb examined the question of how important it is for different medical specialties to work together. He believes physicians should consider developing an exercise program that meets heart as well as orthopedic needs.

Another interesting realization to emerge from the program was that most people who make decisions about insurance coverage, employee benefits or cost containment procedures are younger, healthy members of the population, individuals who ordinarily have little contact with the health care delivery system. Their job is to make medicine more cost-effective. If "sick people" were to make these decisions, some of the paperwork and documentation might be viewed as unnecessary, Gryb says.

Physician perceptions are jolted

One of the most positive results, say participating physicians, was the opportunity to debunk some public perceptions about physicians, perceptions which frequently fall short of reality.

Doctors were amazed to learn, for example, that while most of them had assumed that the public knows how hard they work, mini-interns expressed surprise to find that primary care physicians average 60- and 65-hour work weeks.

Another commonly held public assumption turned out to be "the high-tech notion." Pamela Fennewald, M.D., a specialist in geriatrics and internal medicine, discovered that her interns had the perception that physicians always rely on the latest technology for decision-making.

"So often in the lay press," says Dr. Fennewald, "we read about the latest technology. Yet I learned the public doesn't realize that physicians must depend on other skills besides technology. In my specialty, I depend very heavily on a general knowledge of medicine. In fact," she continues, "one of my interns, Andrea Moore, an elected official on the Lake County Board, thought I could only determine where a patient's liver was by high technology. She had no idea that I knew where the liver border was by percussion."

Dr. Fennewald also discovered that few non-physicians realize how many phone calls doctors receive on an average day. "By noon," she says, "I had at least ten phone calls that had to be returned before my afternoon hours." Consequently, she surmised, it's no wonder patients get angry when they think doctors are ignoring them because they can't always return their calls immediately.

Just keeping pace with participating physicians on their rounds turned out to be a challenge. By Tuesday's debriefing dinner, most of the mini-interns reported they were exhausted. One woman said, "I've walked my legs off. I was almost running to keep up with the doctors."

Empathy and understanding

Mini-interns expressed new empathy for doctors and understanding of the human and professional situations they encounter every day. As for doctors' self-care, Gryb says she was upset to see that "physicians aren't concerned about their own well-being. I saw physicians," she says, "smoking in the doctors' lounge while having a cup of coffee. And overweight doctors are not good examples to their patients."

Police chief Roger H. Stricker of Libertyville was disturbed when he saw patients wasting a doctor's time. "Why are some of these patients even at the office?" he asked. "They truly don't need to see a doctor."

And Rabbi Samuel Gordon wondered how physicians avoided total emotional exhaustion dealing with the physical and psychic complaints of their patients. He says he was impressed with how physicians were able to tailor their approaches to individual patients, but criticized patients, saying "Some patients were argumentative or whiners. Others always had an excuse why they didn't follow the doctors' instructions. I even saw patients that were too passive and seemed to be intimidated by the doctors."

Integrating the insights

Such valuable insights on all sides have proven extremely encouraging to the LCMS. Though the Lake County area is not large, Jane Stein says she believes the community can support a twice-a-year mini-internship. In the spring of 1990, she expects to have twelve interns participate in the program, while those who participated this year will be asked to recommend 1990 participants and to share their experiences.

The only regret of the participating physicians was that they felt they weren't able to give a complete picture of the challenges that face them daily. Mini-interns, they say, did not see the threat of future rationing of medical care, nor did they see the devastating effects that medical malpractice litigation has had on the practice of medicine, nor the government and insurance regulations which restrict physicians' freedom of action. Finally, they say, mini-interns didn't see the possibility that medicine is heading down a road leading to a two-tier health care system, one for the rich and one for the poor.

Still, the resounding success of the 1989 program will doubtless lead to refinements and amendments to future mini-internship programs. Who knows? The Lake County program could start an important trend. ▲

FROM THE ILLINOIS NEWS DEPARTMENT OF PROFESSIONAL REGULATION

This month, Illinois Medicine *resumes its periodic update on actions taken against physicians disciplined under the Medical Practice Act. This information is reprinted from the Illinois Department of Professional Regulation's (IDPR) monthly disciplinary report. IDPR is solely responsible for its content.*

The physician and surgeon license of Ekhail F. Khait, 5240 Cleveland, Skokie, was restored on one (1) year's probation after he successfully petitioned the Department for restoration.

The physician and surgeon, and controlled substances licenses of Lawrence Lerner, 6218 S. Central, Chicago, were revoked after a Department audit revealed a substantial shortage of controlled substances.

The physician and surgeon license of Joseph H. Kennedy, 7715 S. Evans, Chicago, was indefinitely suspended after the Department of the Army Credentials Committee, Fort Rucker, Alabama, revoked his credentials for unprofessional conduct.

The physician and surgeon license of Abbas Poorsattar, 6090 Strathmoor Dr., Rockford, was suspended for ninety (90) days to be followed by one year's probation after he was convicted of a felony.

The physician and surgeon license of Urduja Pulido, 216 N. 12th St., Murphysboro, was summarily suspended after she performed deliveries in her office which should have been performed in a hospital setting because of potential risks.

The physician and surgeon license of Michele R. Holevar, 224 S. Eighth Ave., LaGrange, was reprimanded after she failed to diagnose juvenile diabetes, subsequently resulting in impending coma, during an emergency room examination. She denied that any negligence occurred but agreed to enter into a consent order.

The physician and surgeon license of Bakul K. Pandya, P.O. Box 309, Orland Park, was reprimanded and fined one thousand four hundred dollars ($1,400) after he practiced medicine with an expired license.

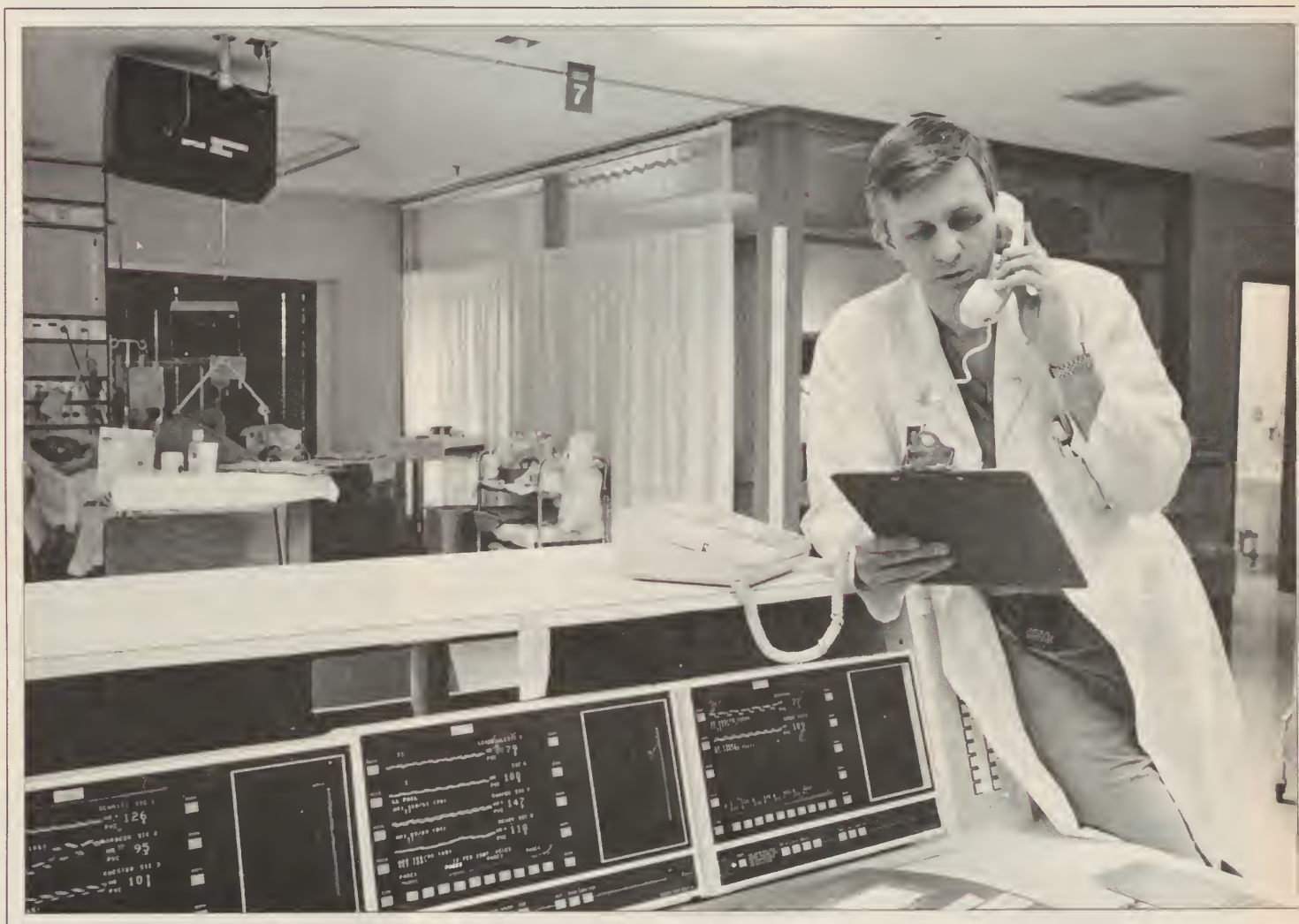
The physician and surgeon license of Michael J. Liston, 11757 Southwest Hwy., Palos Heights was reprimanded and fined one thousand dollars ($1,000) after he practiced medicine with an expired license.

The physician and surgeon license of Timothy D. Brandt, 4602 Main St., Lisle, was reprimanded and fined fifteen hundred dollars ($1,500) after he practiced with an expired license.

The physician and surgeon license of Lee E. Robin, 561 Juniper Dr., Palatine, was suspended after he was involuntarily placed in a mental health facility by the Cook County Circuit Court.

The physician and surgeon license of Edward Neu, 5256 S. Mason, Chicago, was reprimanded and fined one thousand dollars ($1,000) after his license expired and he neglected to renew it but continuted to work without it.

The physicician and surgeon license of David C. Flemming, 819 W. Aldine, Chicago, was reprimanded and fined one thousand, five hundred dollars ($1,500) after he practiced without a renewed license.



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First of a series

Rural health care now: the hospital-closings crisis hits downstate

by Mary Delach Leonard

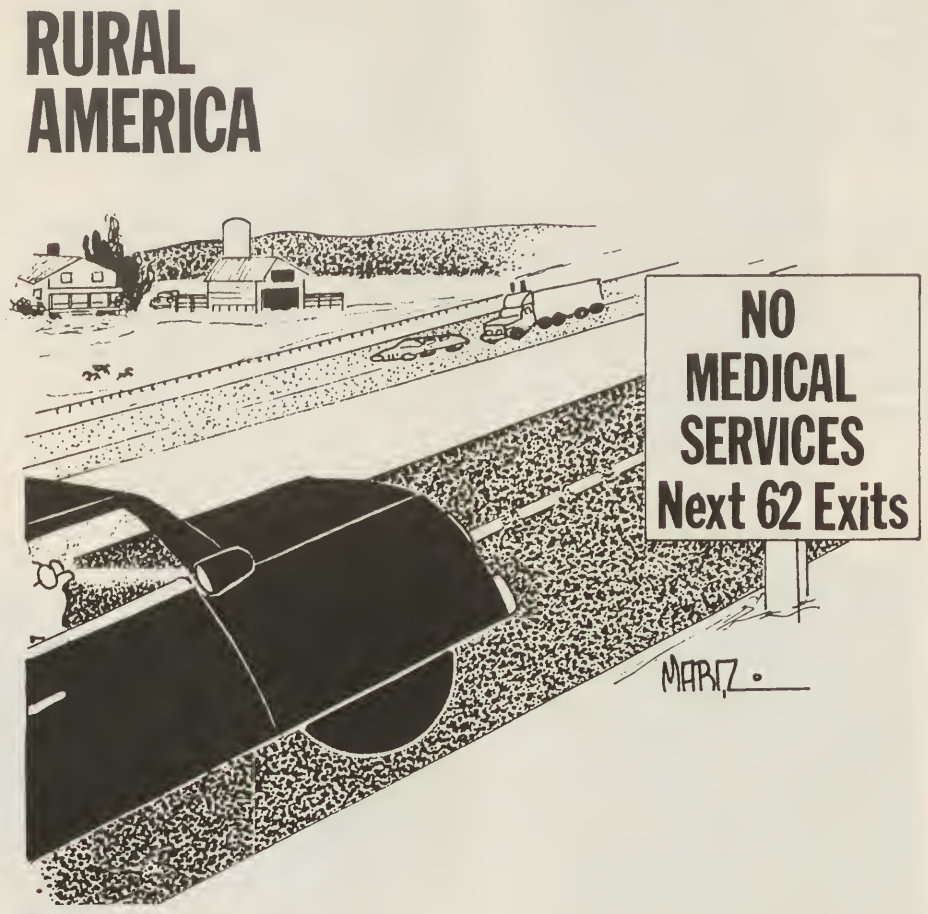


Illustration: Don Marquis

PAINT HAS BEGUN to blister and peel away at the entrance to White Hall Hospital. Though the green welcome mat with the hospital's initials "WHH" is still in place, the doors are locked and no one is inside.

The doors to this 30-bed facility closed for good on September 2, 1988, leaving the 2,900 residents of the town, also called White Hall, without any hospital.

Residents and health care professionals in the area, located 45 miles southwest of Springfield in Green County, have expressed dismay at the hospital's closing.

"Of course it is a tremendous shock to any community when the hospital closes," says Ludwich Dech, M.D., who has practiced in neighboring Roodhouse for 31 years.

"The older people especially were very upset. They still hope that it's going to open again one of these days," says Dr. Dech.

Residents of the community now must travel more than 20 miles for hospital care—something many had already been doing.

"The problem with White Hall is they were really surrounded by hospitals," says Al Grant of the Illinois Department of Public Health (IDPH). "And to compete—as small as they were—with larger rurals including Jacksonville, Carrollton and Carlinville, made it that much tougher."

A complex of problems

White Hall was the sixth rural hospital to close in Illinois since 1986. On December 31, LaHarpe Hospital in rural Hancock County is expected to become the seventh. The other five have been Southern Medical Center in Cairo, Beardstown Hospital in Paxton, Saunders Hospital in Avon and Pearce Hospital in Eldorado. The widening problems of rural health care—hospital closings and shortages of physicians and allied health professionals—have become the focus of a growing number of studies and task forces, some of which have led to action in the Illinois General Assembly. (See *Illinois Medicine,* November 10.)

Lieutenant Governor George Ryan convened a state rural health task force, which has held meetings on the issue during 1989. U.S. Senator Paul Simon (D) has asked the U.S. General Accounting Office (GAO) to study the problem; the GAO's report is expected by the end of the year.

In addition, the Illinois Farm Bureau has a task force and IDPH has researched the issue and held conferences. The Center for Rural Health was recently created in IDPH to assist rural communities in recruiting physicians and developing health care plans.

Low Medicaid and Medicare reimbursement and problems associated with Medicare's prospective payment system are reasons often cited by physicians for hospital closings.

In addition, the exodus of young and middle-aged wage earners to the cities has left many small towns with a large proportion of elderly and poor residents. Those demographics translate to a larger percentage of patients on Medicare and Medicaid.

At Massac Memorial Hospital in Metropolis, for example, Medicare and Medicaid patients account for about 75 percent of the hospital's patients, says John "Jack" Taylor, chairman of the hospital board.

"If we use a CT scan on a Medicaid patient, it will probably pay us around $60 to $75. It costs us $192 for the procedure," says Taylor.

Efforts are underway in Congress to eliminate the Medicare differential between urban and rural hospitals, which health officials say has been devastating to small rural hospitals.

Senators Robert Dole (R-Kansas) and Lloyd Bentsen (D-Texas) have introduced such legislation. In the House, similar bills were introduced by Rep. Robert Michel, R-Peoria and by a rural health care coalition which includes Rep. Terry Bruce (D-Olney), Rep. Richard Durbin (D-Springfield), Rep. Lynn Martin (R-Rockford), and Rep. Glenn Poshard (D-Carterville).

Flight to the cities

Financial problems caused by low Medicare and Medicaid reimbursement are compounded by the loss of private pay patients to larger hospitals in urban areas.

(continued on next page)

Rural hospitals get creative—out of necessity

by Mary Delach Leonard

For brunch on Sundays and "Oriental Night" on Thursdays, Carlinville residents pack into the Lower Deck, a popular restaurant that also happens to be the Carlinville Area Hospital cafeteria.

More than half of the cafeteria's meals are served to the general public, says Ken Reid, director of administrative services. The hospital has also opened up its conference rooms to civic groups: the Rotary Club meets there every Thursday.

The hospital operates a fitness center equipped with Nautilus equipment, indoor walking track, saunas and exercise and aerobics programs. There is also a hospice, a home health department, a clinic for specialists and a van to transport patients free of charge for out-patient services. The hospital also houses a chemical dependency program.

Robert Porteus, Carlinville's chief executive officer, is credited for the aggressive and progressive approach of this 50-bed hospital serving Carlinville and surrounding towns in Macoupin County.

"The primary thing we've kept in mind is that we are a health care facility," said Reid. "We don't want to lose sight of that. But we also realize that we have to be a little more efficient and a little more productive in generating revenues elsewhere."

Creative solutions to tough problems

Aggressive marketing and creative thinking are helping small rural hospitals take a more vital role in their communities, says Barbara Dallas of the Illinois Hospital Association.

Health officials in the state point to Massac Memorial Hospital in Metropolis as an example of aggressive hospital leadership.

"Metropolis is an example of a creative community—a little hospital that is prospering. It has very aggressive management," says Ray Robertson of the Southern Illinois University School of Medicine.

Officials of the 57-bed hospital in Massac County were the first in the state to request assistance from the Center for Rural Health, says Al Grant of IDPH. The hospital is establishing primary care centers to serve a four-county region at the southern tip of the state, and expanding specialty services; it has also started a swing-bed system, and plans call for the possible opening of birthing facilities.

John Taylor, chairman of the hospital board, said community and civic groups are routinely invited to meet with the hospital board to promote awareness.

"There is always a percentage of your people who think bigger is better. And if we get those people into our hospital and do our job—if we give them service—we won't have trouble keeping them."

Despite problems associated with low Medicare and Medicaid reimbursement and a flux of private pay patients to larger hospitals, including those in Paducah, Kentucky, just across the river, the hospital is staying financially healthy, said Taylor.



Carlinville Hospital has added food and entertainment to its roster.

The hospital is one of the few in the United States which owns and operates its own ambulance service.

"I call it our bananas—our loss leader," said Taylor, a retired grocery store operator. "The ambulance service costs us money, but we couldn't afford to do without it. It helps get people into our hospital."

Taylor said strong marketing is a key to survival.

"We as small rural hospitals are improving the quality of life. We're reaching out in every way. We're bringing in sophisticated equipment to save lives. We work really hard and we're doing a good job. But we're not selling ourselves." ▲

(continued from page 10)

"The perception in rural communities, in a lot of cases, is that bigger is better," says Grant. "They flee to urban areas for health care. They flee to urban areas for shopping. So with the transportation ability of our rural citizens, they are going—they are shopping. The problem with that is they're leaving behind those who don't have transportation or those who can't afford to make the trip."

An Illinois Farm Bureau survey of members in 67 rural counties last year reflected contradictory attitudes about health care. While 92 percent of the respondents who were hospitalized in the hospital nearest their home rated the care good or excellent, 48 percent chose not to be admitted to the nearest hospital.

"I'm surprised that people don't mind traveling so far anymore. If they think there is a better hospital, in some cases they will drive right past their own hospital," says Nola Gramm of the Farm Bureau's governmental affairs division.

People were not supporting the hospital when it was open and now that it's closed they really do miss it. "You don't miss your water until the well goes dry."

Grant points to the failure of Southern Medical Center in Cairo, which closed in December 1986.

"The utilization of the hospital in Cairo was public aid and Medicare patients and when you run a hospital with no private pay, there's only one answer, and that's failure," says Grant. "The private pay in that community left and purchased care outside of it."

People in Cairo now drive 30 or more miles to hospitals in Anna, Metropolis and Carbondale. Or they cross state borders to Sikeston or Cape Girardeau in Missouri or Paducah in Kentucky.

"People were not supporting the hospital when it was open and now that it's closed they really do miss it. They miss it because there's a fear in the community that in the case of an emergency they might not make it 30 to 35 miles," says Grant.

"One of the local citizens was quoted," he adds, "and I just love his quote: 'You don't miss your water until the well goes dry'."

The impact on the community

In most cases, when a hospital closes, the community is left emotionally stunned, with residents concerned most about the loss of emergency care. Many also fear that physicians will leave and the hospital's medical records will be lost.

Medical records are required by law to be maintained in the community. When a hospital closes, records may be returned to physicians or stored in community health clinics, says Grant. "To retain our doctors who are practicing when a hospital closes is not impossible," he says. "It's not ideal, but most of our doctors have been willing to stay and work with the system—especially if they've gotten involved with the community."

In White Hall, one doctor stayed on part-time after the hospital closed. There are also six doctors in neighboring communities, says Dr. Dech. But he worries about attracting young physicians.

"The county still has enough physicians to take care of the population, but the question is, 'What happens in 30 years?'"

White Hall has an ambulance service, but no paramedics, and a major concern is the handling of acute emergencies, says Dr. Dech. The community's senior citizens have been most affected. They were familiar with the small hospital and acquainted with the staff.

"Senior citizens require much more health care than the younger population, and it's easier for the younger population to travel some distance if they have to," says Dr. Dech. "Older folks need someone to take them."

When a hospital closes, it also has an impact on the local economy.

"Community members must recognize that the hospital is, in most cases, the largest employer in the town and, in many cases, in the county. If they don't support that local employer, they will lose that hospital," says Barbara Dallas, assistant director of small rural and public hospitals at the Illinois Hospital Association.

"New businesses will not even consider locating a factory or opening an insurance office in a town without a hospital," says Dallas. "You not only impact what is already there, but what could potentially be there. It is actually the beginning of the demise of that town."

Small rural hospitals need to be more aggressive in marketing their services, Dallas thinks, adding that "They need to toot their own horn about the quality of services they can provide."

Change will come

A changing health care environment is forcing small rural hospitals to change.

"The small rural hospitals realize that with the much lower utilization of inpatient services—those who occupy a bed overnight—they are changing their services to outpatient. They are looking at establishing long-term care beds like nursing homes and intermediate care. They are diversifying," Dallas says. Depending on the needs of the community, diversified services might include joint ventures with other hospitals, swing-beds and establishing clinics for specialists in such areas as cardiology, oncology or orthopedics, she adds.

"We know that we can no longer stay in the hospital four days for minor surgery like we used to be able to. Those kinds of things are now being done on an outpatient basis. So, instead of sending those patients off to the cities, bring that specialty back to the community for your customers."

Dallas said changes are coming about as hospitals adapt to meet the needs of their communities, but community support is vital.

"We are rapidly approaching a crisis. Unless these steps are taken, we will lose the small rural hospital," she says. ▲



Physician spouses attending the ISMS Auxiliary Fall Conference in Bloomington hear speakers describe new challenges facing medical families.

Coping with personal health issues: ISMS auxiliary hears of challenges

THE CHALLENGES of educating adolescents about AIDS, coping with a substance-abusing physician spouse, and raising doctors' kids were topics presented at the Illinois State Medical Society Auxiliary (ISMSA) fall conference in Bloomington October 17.

"It's the only function in which we have a chance to bring an educational forum to our members from all over the state," said ISMSA president Nancy Hoffmann of Rockford. "We hoped these topics would reach a broad spectrum of people."

Ken Haller, M.D., a St. Louis pediatrician, told some 90 auxiliary members of the importance of educating teens about AIDS. "There are a large number of people in their 20s with symptoms of AIDS, and because it can take up to 10 years to develop AIDS symptoms, these people probably were infected as teens," he said. "If there's any stage in life where people do not think ten years into the future, it's the period from about 13 to 19 years old. Teenagers have to have a very strong cause and effect relationship between things. It's very hard for [teenagers] to see that something they're doing now is going to affect them later."

Help for recovering MD spouses

Kathy Angres, R.N., and her husband Dan Angres, M.D., a member of the ISMS Physicians' Assistance Committee and a recovering chemically dependent physician, emphasized the need to seek professional help both for chemically dependent physicians and their spouses. Ms. Angres told the audience, "Chemical dependency does not go away by itself. It only gets better through [effective] programs and specialized treatments." Her husband, a psychiatrist, began a treatment center for addicted physicians and other professionals five years ago.

His wife, who runs a co-dependency program, emphasized the importance of seeking support for the "significant other" because of the high susceptibility medical families have to co-dependency, which she characterized as "a pattern of living, coping and problem solving created and maintained by a set of dysfunctional rules within our family or social system." She said, "Spouses of addicts, recovering addicts and adult children of addicts are at high risk for co-dependency."

"The best way to cope with impairment is through detachment, letting go of our obsessiveness with another person's behavior, especially chemical dependency," she told the audience. "Feeling is allowing yourself to have emotions and allowing them to be out there. Breaking the silence is talking and we need to talk to 'safe' people, not just to anybody about this. And lastly, we need to love ourselves and that's taking care of ourselves."

"There is a tremendously high recovery rate for physicians who go through a treatment process, which is typically very structured with extended monitoring," Dr. Angres said. "The two-year average recovery rate, which means two years of continued abstinence from drug use, is greater than 92 percent. The five-year recovery rates are about 90 percent," he said. "Licensure boards are very supportive of rehabilitation treatment and re-entry into the medical field," Dr. Angres emphasized.

Individuals who need help or who know of someone who needs treatment can call Violet M. Eggert, M.D., medical director of the ISMS physicians' assistance program at 312-580-2499, with a guarantee of absolute confidentiality. Dr. Angres added, "What begins is a very cautious and caring investigatory process, because our absolute priority is to motivate someone into the treatment process."

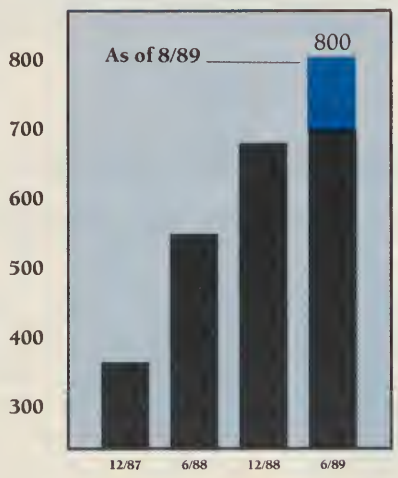
Doctors: meeting their children's needs

Speaking about raising doctors' kids, Anthony Perino, Ph.D., a Peoria psychologist told auxilians of the importance of physician fathers spending time with their children, despite having to deal with stresses of the medical profession. "Children need uninterrupted time and it's very difficult to establish an in-depth relationship with a child when time is so drastically restricted," he said.

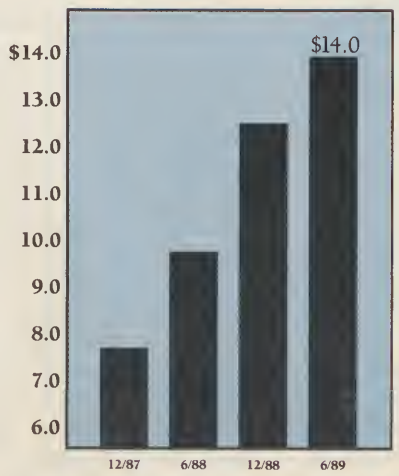
Controlling a spouse's stress level, according to Dr. Perino, depends on "episodic breaks, and that means getting away from medicine, as hard as it may sound. One vacation throughout the year won't do it," he emphasized. Perino advised that "medical families can reduce stress levels much more efficiently," by taking shorter vacations throughout the year rather than only one or two breaks. This gives them more "regular" time off with the children, so a spouse's stress level decreases. "You get back to a level of equality with regard to the burden that you have disciplining the children. And when the emotional atmosphere or tone in the home is positive, the children will do better," Dr. Perino said. ▲

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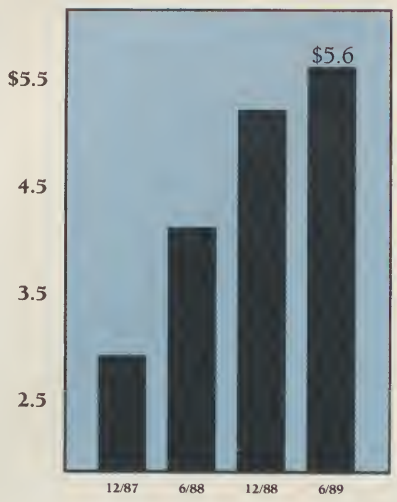
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Douglas County residents decline to fund only hospital

AN INEVITABLE end within a year is the forecast hospital officials and county board members are painting for the financially-strapped Douglas County Jarman Memorial Hospital in Tuscola, following Douglas County residents' rejection November 7, of a tax proposal that would have provided much-needed funding for the county-owned facility.

The ballot question, "Shall Douglas County levy an annual tax of not to exceed 25 percent per $100 of assessed valuation for the purpose of maintaining public nonsectarian hospitals?" lost when 1956 residents voted in favor of the tax, while 2369 opposed. As a result, the hospital could become the seventh to close in rural downstate Illinois since 1986.

"The whole driving factor behind keeping the hospital open is dollars," said Mark Fedyk, Jarman Memorial Hospital administrator. "But given the failing referendum and the county board's financial situation, we are entirely dependent upon more patient admissions by physicians. If our medical staff would act as a unit, a supporter of the hospital, not by voice, but by action to increase hospital utilization, our cash flow situation could be turned around."

But, following the referendum's failure, Fedyk cancelled interviews with two doctors considering relocating to Douglas County. "The additional revenues would have made a good financial package possible, allowing for sufficient physician recruitment." Without additional tax revenue, the doctors could not have been guaranteed incomes, Fedyk said.

Efforts failed on tax question

"We did work hard for the referendum, but talking about tax money is taboo," said Raymond Climaco, M.D., of Arcola. "I have been here for 10 years and ever since, I've heard this hospital is going to close, so I just cannot believe it. If it does close, those who use the hospital won't feel the effect until we really shut down. For a minor injury, patients will have to go to Champaign or Mattoon for treatment."

"It would be catastrophic for this hospital to close in this county, just as it would be in any other county with only one hospital," said John N. Cunningham, D.O., Douglas County Medical Society president and secretary-treasurer of Jarman's medical staff. "The people that will be most hurt, if the hospital closes, are the old and those without transportation. In addition, we will never be able to recruit another physician to this county," he added.

Dr. Climaco said there is talk of shutting down the inpatient part of the hospital while maintaining only the x-ray and laboratory services. However, Fedyk says financial comparisons show it would cost more to run just an outpatient facility rather than an inpatient/outpatient facility.

The county board and the hospital management group is scheduled to meet with the Illinois Hospital Association December 5 to discuss possible options for the hospital. "However, we're entirely dependent upon policy that will be dictated by the county board," said Fedyk.

At least two Douglas county board members agree the hospital is heading toward closure. County board member Norm Willoughby said there is a "fair amount of time to look at other possibilities," but when asked if he could foresee a solution, he replied, "not really."

County board member Alan Michener agreed there won't be any "grave" decisions for at least six months, but he said the hospital "is probably going to close." ▲

Cook County summit

(continued from page 2)

Dr. Turnock said that a "broadly-based group" comprised the summit, and that while participants may have different interpretations of what constitutes fair representation, it is up to the committees to ensure that adequate input from interested constituencies occurs during the summit's December public hearings. Dr. Turnock also said that the three political leaders—Dunne, Thompson and Daley—had made the summit appointments and that, "None of us appointed ourselves."

Different tone at second meeting

The tone was considerably different at the system design and management committee's first meeting on Nov. 14. Absent was the political dissension that characterized the Nov. 3 meeting. Instead, Dr. Krieg submitted a general committee charge and six draft objectives that the committee adopted in business-like fashion.

The committee decided that it should serve as the policy analysis arm for the overall summit process. To this end, the committee will collect and analyze necessary information on current health care providers, as well as funding sources and levels. It will also examine major institutional issues, such as the roles of Cook County Hospital, University of Illinois Hospital, Provident Hospital and individual ambulatory care providers.

However, Cook County Hospital director Terrence Hansen had some unsettling news. He told the committee, of which he is a member, that the County Board needs to make two major financial decisions regarding the crumbling 1,000-bed facility well before scheduled completion of the summit's work.

First, in order to avoid loss of its accreditation, the hospital is being told it must spend $100 million to $150 million to transform its open wards to semi-private rooms, this in addition to an already approved $35 million in life-safety improvements to satisfy Medicare and Medicaid requirements.

Second, Hansen said the County Board will decide in January whether to award a contract to install a computer information system linking Cook County Hospital, Oak Forest Hospital, Cook County Jail, all the county's suburban clinics and half of the city's clinics. Such a system could alleviate one of the major inadequacies the summit is supposed to address.

"I suggest to you that it is absolutely ludicrous to put $35 million into those buildings, let alone $135 million," said Hansen. Conversely, he said a new information system presents a "here and now" opportunity to address one aspect of the access to quality health care problem. "To me, access is a whole lot of things, one of which is [patient] information [being] available to providers in the health care system," he said.

Summit topics and hearings

The summit is to focus on several topics. First, it will address which levels of government have responsibility for ensuring access to quality health care. Second, summit participants will try to determine whether specific populations should be targeted for special consideration, and if so, which ones. Identification of specific services to be included in a coordinated plan will be addressed, as will the plan's design, governance and financing.

The deadline for submitting a report to the three heads of government is mid-April, so necessary legislation can be drafted for introduction in the General Assembly's spring session. During November, the policy steering committee will be visiting several city and county health care facilities to acquaint themselves with problems of health care workers and their clients.

In December, the policy steering committee will sponsor a series of six public hearings, four in the city and two in suburban Cook County. The precise location and schedule of the hearings, as well as summit participants' suggestions for questions during the hearings, will be disclosed at the committee's next meeting on Nov. 28. ▲

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Living will, power of attorney ease crisis

Before Illinois patients become terminally ill or incompetent to make their own health care decisions, it is possible for them to designate two types of advance directives: durable power of attorney for health care and "Living will."

A living will is available to "any person of sound mind" over 18 years old, or emancipated minor (aged 16 to 18). The Illinois State Medical Society (ISMS) publishes a pamphlet, "A Physician's Guide to the Illinois Living Will Act," available on request.

In addition to the Act's provisions, the power of attorney law allows individuals to name an agent to make decisions in the event of incompetence. Patients must notify health care providers of the document. The agent makes decisions on medical treatment, including withdrawal of life-prolonging measures. ▲

Terminally ill ruling

(continued from page 1)

tee and consultant to the Medical Legal Council. "It's heavily constrained according to the provisions described, but up to now we've not been permitted to withdraw nutrition or hydration, once they've been started. It probably will allow for better management of patients in such lamentable conditions."

But John J. La Puma, M.D., director of the center for clinical ethics at Lutheran General Hospital-Park Ridge, said, "I think [the ruling] is cumbersome and unhelpful. Families don't want to show up in court to make medical decisions for their loved ones. The idea of taking this to court every time it occurs is untenable."

Geoffrey Bland, M.D., J.D., chairman of the ISMS Medical Legal Council, said, "This ruling will put a significant burden on physicians and quite possibly on the judicial system." Dr. Bland, a Springfield family practitioner, added, "It highlights the importance of executing a living will or durable power of attorney."

ISMS policy on life-prolonging treatment reads in part, "Even if death is not imminent, but a patient's coma is beyond doubt irreversible and there are adequate safeguards . . . it is not unethical to discontinue all means of life-prolonging medical treatment [including nutrition and hydration]." ▲

Generic Drugs

(continued from page 1)

mulary when it lost its Food and Drug Administration (FDA) bio-equivalency rating, automatically triggering deletion of the drug from IDPH's Illinois drug product selection formulary. Bolar's generic can still be prescribed, though not as an equivalent to Dyazide. On October 13, IDPH released its updated formulary notice deleting the two generics. The action does not affect reimbursement for Dyazide or for the Bolar generic from the Illinois Department of Public Aid.

The October 13 update noted that the Vitarine generic had already been pulled from the market; and mandated that the Bolar generic can no longer be substituted by a pharmacist automatically. Permission of the prescribing physician when the prescription is written generically, or when the physician, having written Dyazide, gives explicit permission to substitute, is now needed.

Joseph B. Perez, M.D., chairman of the Illinois State Medical Society (ISMS) Committee on Drugs and Therapeutics, expressed support for the IDPH action.

"Every physician is aware of the problems now with generics," said Dr. Perez, a Rockford GP. "The biggest problem is, we don't know the bio-equivalency of generics as we do for brand-name drugs."

The IDPH action tracks with ISMS policy, which states, "ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary."

Albino Bismonte, M.D., a Gurnee pediatrician who serves as an Illinois delegate to the American Medical Association's hospital medical staff section (AMA-HMSS), has introduced a generic drugs resolution for debate at the AMA-HMSS policy meeting. The resolution asks that the "AMA ask the FDA to amend the approval process for generic drugs so that the FDA can assure the public that all future and current generic drugs have the same therapeutic effect as the brand-name product."

The IDPH and FDA actions followed revelations that both drug companies had demonstrated problems with their generics testing.

Vitarine had allegedly run a bio-equivalency test between two batches of the commercial brand Dyazide, instead of between Dyazide and the generic product. Vitarine is now under federal investigation.

Bolar had run two test formulations. According to Theresa Moffett, administrator of IDPH's drug product selection program, one passed FDA criteria for bio-equivalency and the other did not. At some point in the examination process, the lot numbers of the batches were exchanged, leading to speculation to whether the approved lot was the formulation currently marketed.

FDA's head moves on

In another development, FDA Commissioner Frank Young will leave the department in December to take a top position within the Department of Health and Human Services (HHS), according to FDA officials.

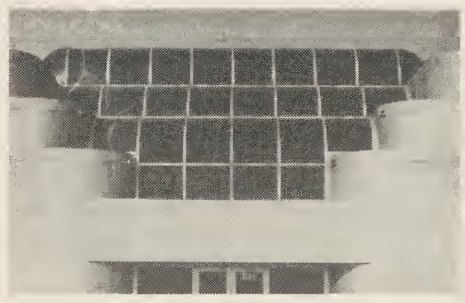
News media have reported that Young and the FDA have been criticized for lax regulation of drug manufacturers. But FDA officials said this was not the reason for Young's move.

Other critics rapped the White House for allegedly hamstringing the FDA through a policy of neglect. "[Young's] intentions were good and he did his best when problems were brought to light," Rep. John Dingell (D-Mich.), told the *Chicago Tribune.* Dingell is chairman of the House Energy and Commerce Investigations Subcommittee, which uncovered allegations of fraud and corruption in the generics industry. "But he was handicapped," said Dingell, "by the budgets and attitudes of an administration that let the agency go to seed."

Young's new job will be to coordinate HHS development and use of technology, including biotechnology, nutrition and food safety. ▲

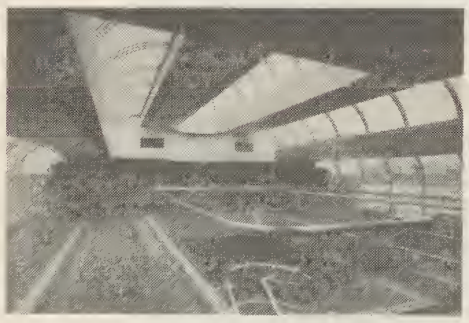
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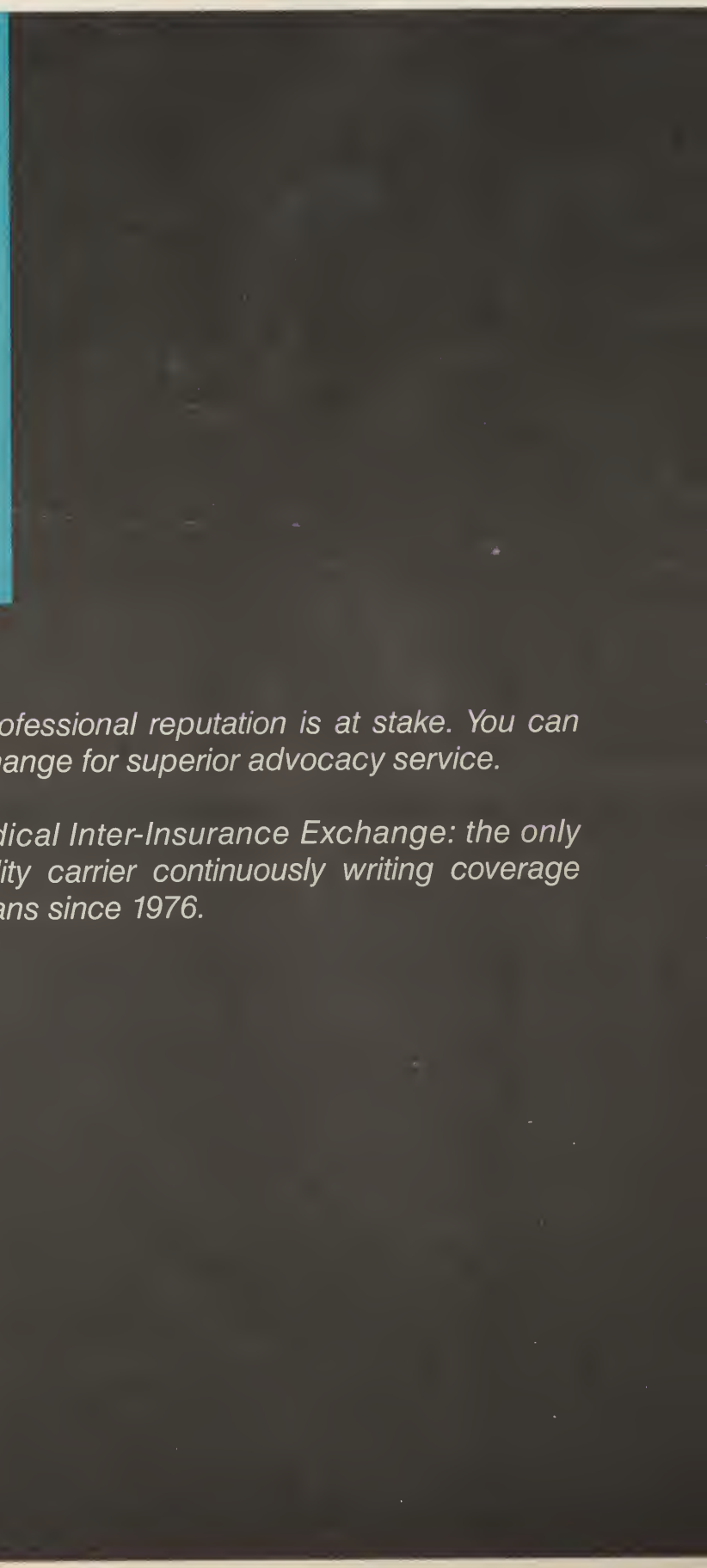
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Authorities look at physician billing practices . . . 15

Illinois Medicine

December 8, 1989

ILLINOIS STATE MEDICAL SOCIETY

Summit public hearings set to begin in mid-December

by Kevin O'Brien

PUBLIC HEARINGS on Chicago and Cook County's health care delivery crisis are scheduled to begin December 14 and will last into mid-January, officials announced on November 28.

At their second meeting, members of the Chicago and Cook County health care summit policy steering committee, one of two summit committees, approved dates and sites for six of nine proposed public hearings to be held throughout the city and suburbs. The remaining proposed hearings need to be rescheduled, and a fourth may be added in the Roseland community on the city's south side. Committee members also approved a draft of suggested questions to guide the testimony witnesses will present.

The hearings signal a significant step in the process, as they will provide a major source of information upon which summit recommendations will be based, and provide the public forum summit leaders hope will address earlier criticism of the process. At the summit's first meeting November 3, some members criticized the composition of summit committees as being unrepresentative of the people who actually use health care services in Cook County.

The hearings will take place on weekday evenings and Saturdays, two of them in Cook County suburbs and

(continued on page 18)



Wm. Daniels/The Photo Partners

Members of the summit policy steering committee tour Cook County Hospital on Nov. 14 as part of their deliberations.

Illinois abortion case settled



Wm. Daniels/The Photo Partners

(L to R) Illinois Attorney General Neil F. Hartigan, IDPH Director Bernard J. Turnock, M.D., and ACLU attorney Colleen Connell announce settlement of the controversial Turnock v. Ragsdale *abortion case.*

by Kevin O'Brien

FOLLOWING MORE than three months of intense negotiations, Illinois Attorney General Neil F. Hartigan announced a settlement in the controversial *Turnock v. Ragsdale* abortion case, averting a December hearing in the U.S. Supreme Court.

Joining Hartigan and attorneys from his office in a November 22 press conference to announce the settlement were Illinois Department of Public Health (IDPH) Director Bernard J. Turnock, M.D., the named defendant in the original suit; lawyers for the American Civil Liberties Union (ACLU) representing Rockford physician Richard T. Ragsdale, M.D.; and others involved in the negotiations.

Hartigan said the settlement will protect a woman's constitutional right to choose to have an abortion, while still allowing the state to set minimum health standards for abortion clinics.

"With the agreement reached today, we believe that we now have a system that addresses the public health concerns related to abortions performed in ambulatory surgical clinics," said Hartigan. "This settlement accomplishes this without any overly intrusive effect on the cost or availability of those services."

(continued on page 17)

Midwives' suit seeks to clarify Illinois law

IN AN EFFORT to clarify whether midwifery is illegal under the Illinois Medical Practice Act, two downstate women charged last year with practicing medicine without a license filed suit November 16 in U.S. District Court in Danville against the State of Illinois.

"This lawsuit is asking the judge to declare under the U.S. Constitution what are the rights of a traditional midwife and of Illinois citizens who wish to receive the services of a traditional midwife," said William Zukosky, lead attorney for the plaintiffs. The defendants in this case, officials at the Illinois Department of Professional Regulation (IDPR), the Illinois Department of Public Health (IDPH) and the Attorney General's office, "are responsible for interpreting and enforcing the Medical Practice Act and other Illinois statutes in the health field," Zukosky added.

"The biggest significance of this suit," said Illinois State Medical Society (ISMS) general counsel Saul J. Morse, "is the impact or effect it will have on the Medical Practice Act, and whether there will ultimately be a finding that the delivery of a child is, or is not the practice of medicine. The outcome of this suit may mandate that every delivery other than emergency situations must be assisted by a physician," Morse said.

Medical Practice Act and midwives

The practice of midwifery has been at issue in Illinois since early in this century. The Medical Practice Act of 1923 initially provided for midwife licensure, but in 1965 the Illinois

(continued on page 18)



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Looking Northward: *Hugh Scully M.D., of the Canadian Medical Association addresses the ISMS All Member Conference* *(see page 12).*

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Lutheran General shuts down its Lincoln Park facility

THE BOARD of directors of Lutheran General Hospital-Park Ridge voted November 21 to close the hospital's 300-bed Lincoln Park facility on Chicago's near north side effective December 8, two years after that branch's inauguration. The board cited increased operating costs, competition with other area hospitals for patients, and low Medicare and Medicaid reimbursements.

"It's disheartening and frustrating to see that even with the increase in volume we've had [the facility had been averaging about 100 acute patients and 30 skilled-nursing patients in recent months], the increase in Medicare and Medicaid reimbursements has almost stood still while operating costs have gone up," said Lutheran General Hospital president Roger S. Hunt, in making the announcement November 22.

The decision to close Lutheran General Hospital-Lincoln Park came two weeks after negotiations aimed at merging LGH-LP with nearby Grant Hospital broke down, and days after it became evident a physician group would not be able to raise the capital to buy it.

Physician offices in the professional office building adjacent to the hospital, and the Lutheran General Medical Group, will remain open, Hunt said. A final decision regarding use of the site at 2035 N. Lincoln Avenue, will likely be made within six months, Hunt added.

Lutheran General Hospital-Lincoln Park has a 108-year history. Established in 1881 as Augustana Hospital, the facility was noted for its surgery department. When the American Lutheran Church, which owned Augustana, merged in the early 1980s with the Lutheran Church in America, owner of Lutheran General-Park Ridge, church administrators saw the 1982 affiliation and 1987 merger of the two facilities as a natural step.



Wm. Daniels/The PhotoPartners

Lutheran General Hospital—Lincoln Park.

But the Lincoln Park facility soon fell victim to cost-based problems. "When you are the smallest hospital in a community with many larger hospitals with empty beds," Hunt commented, "you realize that in the long run, we could continue to invest further in the hospital, but success could only have come with the failure of some other area hospital."

Hunt said of the facility's staff that "Their well-being is our top priority." "A number" of the 250-plus members of the Lincoln Park medical staff have admitting privileges at the 712-bed, 750-staff-member Park Ridge facility, he said, adding "our expectation is most of them will remain in the Lincoln Park area. Many of them," he noted, "already have admitting privileges at area hospitals.

The closure will make Lutheran General-Lincoln Park the 13th hospital to close in Chicago since 1985 and the third to close this year, according to a spokesperson for the Metropolitan Chicago Health Care Council. ▲

Clinical lab act: prepare now

by Karen Sandrick

DECEMBER 31, 1989, the deadline for Illinois physicians to submit their applications for operating clinical laboratories in their offices is fast approaching, and many physicians are confused and anxious about the classification of their laboratories, the proficiency testing and quality control procedures they may be required to perform, and the personnel they may have to hire to process lab tests. "Physicians' questions about the regulations involve, 'What does this mean? What category am I going to fall into? And what am I going to be required to do?'" says Louis Owano, M.D., chairman of the department of pathology at SwedishAmerican Hospital in Rockford.

Doctors need to work now, say experts, to ensure compliance with the new law.

The main area of uncertainty for Illinois physicians who operate clinical laboratories in their offices lies in the distinction between labs that require a class I permit versus those that require a class II permit.

The class I permit covers laboratories that perform "simple" tests; class II covers labs that conduct more complex tests. But the Illinois Department of Public Health (IDPH) has not yet reached a final consensus about which tests fall into these categories. "The regulations state that it is IDPH's responsibility to provide a list of what it considers to be simple tests, but that list is not available yet," Dr. Owano explains.

Registration class: where most physicians will end up

Ken Mitchell, administrator of the standards section in IDPH's division of health care facilities and programs, stresses that this "is not as big a problem as it seems."

In the first place, Mitchell observes, most physician office labs probably will fall into the lowest regulatory level, the registration class. "We get 20-25 calls a day in the office, and based on those calls, I would say that 70 percent of the physicians will fall into the registration class," he says.

"The regulations provide a list of 12 tests for the registration class (see *Illinois Medicine,* September 1, 1989),

(continued on page 17)

Criteria for identifying simple tests

- Interpretation of visual signals by pattern recognition, color definition or numeric information using an established control example which can be observed directly by the operator and requires no manipulation or interpolation by the operator to derive a result.
- Use of simple addition, subtraction, multiplication, or division.
- Use of manufacturer-prepared reagents or solutions which are combined without requiring numerous specific calibrated volume measurements or sequential applications.

Qualifications of laboratory personnel

- Medical Technician
  60 hours of academic credit in chemistry or biology and medical laboratory curriculum.
  High school diploma and one year in a technician training program.
  High school diploma and completion of a military medical laboratory course.
- Laboratory Assistant
  Is employed in a laboratory.
  Meets education/experience requirements of laboratory director.
  Functions only under direct supervision of director, supervisor or technologist.

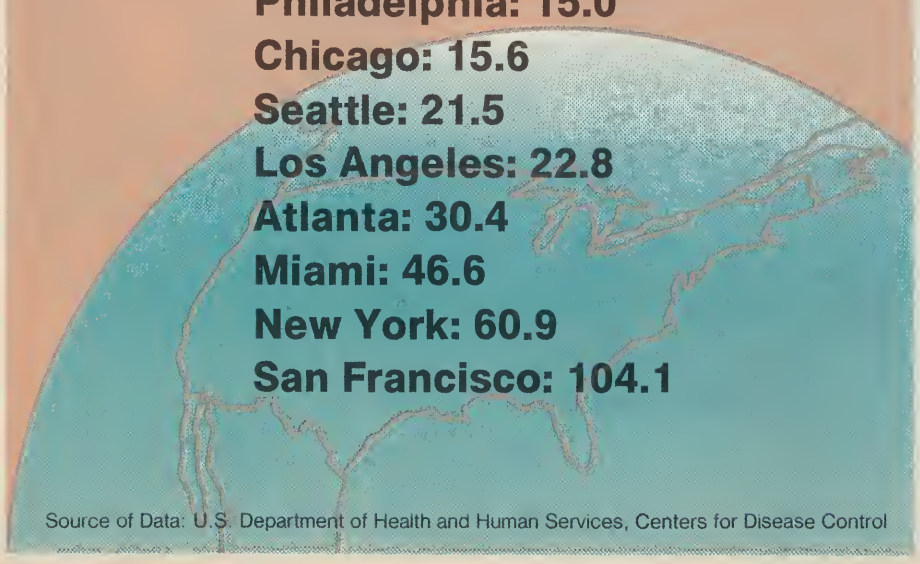
Physician Facts

World AIDS Day–December 1

On Dec. 1, the World Health Organization sponsored World AIDS Day. The Day was intended to "heighten awareness about the risk of HIV infection and AIDS disease; strengthen AIDS prevention activities . . . promote respect and care for people with AIDS . . . and contribute to lasting dialogue" on AIDS throughout the world, according to the World AIDS Day Newsletter.

Some major U.S. metropolitan areas and their incidence of AIDS

(Rates per 100,000 population, September 1988–August 1989)



Source of Data: U.S. Department of Health and Human Services, Centers for Disease Control

Physicians reminded of service occupation tax

THOSE FEW Illinois physicians who think they may be affected by changes in the service occupation tax collection are reminded that they have until January 1, 1990 to register with the Illinois Department of Revenue (IDR).

Under sales tax reform effective January 1, physicians who transfer merchandise through their service or practice will be required to collect the state and local taxes on that merchandise and to itemize their bills—but only if that merchandise totals more than 35 percent of the doctor's total charge.

Due to efforts of Illinois State Medical Society lobbyists and IDR officials, the change is expected to affect only a few physicians. Originally, the service occupation tax threshold was 10 percent, but was raised to 35 percent for the medical profession.

In addition, physicians will be allowed to compute the 35 percent threshold either on the basis of their gross sales or individual transactions. Physicians are urged to consult their attorneys or accountants to determine if they are affected. Further information can be obtained from the IDR at 217-782-3344. ▲

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Southern Illinois group launches obstetrical crisis plan

THE SOUTHERN ILLINOIS Medical Association (SIMA) has launched an action plan to deal with the current obstetrical care shortage in southern Illinois.

The plan includes proposals for malpractice indemnification, Medicaid claim-related tort reform, perinatal birthing centers, loan discounts for health care professionals and midwife certification.

"Our plan involves a two-part strategy," said William Hays, M.D., SIMA first vice-president. "First, we must enhance public awareness. Second, we're coming forward with solutions, for the legislature to look at."

SIMA has proposed several measures summarized in a position paper on obstetrical care. Eugene P. Johnson, M.D., Illinois State Medical Society (ISMS) president acknowledged the problem, but called the proposals "impractical at this time," adding that more study needs to be done "to address the fact that there is an overall shortage in many southern Illinois areas, not only in OB, but in general surgical care, family practice and general medicine. These issues ought to be addressed at the same time, hopefully by the same type of mechanisms," he said.

Malpractice indemnification is among items SIMA addressed. "We are calling upon the state to provide some assistance for those physicians who assume a heavy load in caring for public aid patients requiring obstetric services, said Delbert Harris, M.D., SIMA president. These physicians have to pay extremely high [malpractice insurance] premiums and are receiving very low reimbursement." The Illinois state legislature had approved malpractice indemnification (S.B. 1303) in its 1989 spring session. However, Governor James Thompson vetoed the measure because the legislature failed to appropriate necessary funding.

SIMA is also advocating more use of certified nurse-midwives (CNMs). "SIMA supports the concept of physician, hospital, or clinic-salaried CNMs who are overseen or supervised by appropriate, qualified physicians," SIMA's policy statement reads.

ISMS board looks at SIMA proposals

The ISMS Board of Trustees reviewed and declined to adopt a resolution on November 17 which would have urged the Illinois Department of Public Aid (IDPA) to contract with qualified physicians and certified nurse midwives to provide obstetrical care in rural areas and to bring those contract physicians under the umbrella of state malpractice coverage. Instead, the board adopted a statement which reads in part, "The Society has successfully sought significant increases in public aid OB rates. OB fees received a substantial boost on September 1, 1989. The board believes any available additional monies would be better spent on fee increases than selective contracting or assumption of liability by the state."

Added Dr. Johnson, "Malpractice problems really ought to be solved throughout the state by getting the legislature to cap non-economic damage awards."

On the issue of certified nurse-midwives, the ISMS board said it "fails to see how this resolution will improve access where there may be a shortage of supervising physicians."

SIMA is also proposing the implementation of hospital-based perinatal birthing centers in level I hospitals "to reduce the expense of the hospital and to provide basic services for uncomplicated obstetrical patients," said Dr. Harris.

At its November 17 board meeting, ISMS adopted a resolution "supporting the concept of physician-directed and supervised low-risk obstetrical services within underserved, rural community hospitals with service to include appropriate prenatal care and transportation to higher level obstetrical centers."

SIMA has also proposed that family physicians and obstetricians receive state-backed loans discounted by $20,000 "for each year the physician works in a manpower-deficient area defined by the State of Illinois," according to its position paper. ▲



Darrell Linne/Mt. Vernon Register News

SIMA members William Hayes, M.D., Arthur Smith, M.D., Delbert Harris, M.D. and Roger Klam, M.D.

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REPORT FOR *Illinois Physicians*

MEDICARE NOTES

FACT SHEET ON GRAMM-RUDMAN-HOLLINGS BILL

The Balanced Budget and Emergency Deficit Control Act of 1985 (known as the Gramm-Rudman-Hollings Bill) establishes an automatic budget reduction procedure for fiscal years 1986 through 1991 which provides for reductions in Federal programs should the budget deficit exceed specific amounts for any year. For FY 1990, the effect on Medicare payments is as follows:

- Medicare payments for services furnished on or after October 17, 1989, and before October 1, 1990, are reduced by 2 percent. Although the reduction in Medicare payment provided in the law is limited to 2 percent for FY 1990, 2.092 percent must be withheld for services on or after October 17, 1989 to accomplish a 2 percent reduction for FY 1990.
- The reduction applies to all Part B services, supplies and equipment reimbursed by a carrier. This includes but is not limited to services reimbursed on a reasonable charge basis, the monthly capitation payment (MCP) for physicians' outpatient maintenance dialysis services, payments for durable medical equipment (DME) and clinical diagnostic laboratory services subject to fee schedules and payment to ASCs.

  The calculation of the amount of the charges subject to the deductible is not affected by the payment reduction.
- For assigned claims, the beneficiary's coinsurance responsibility is not affected. That is, the beneficiary is obligated to pay only 20 percent of the reasonable charge after the deductible has been met. However, the beneficiary's out-of-pocket expenses will be increased for unassigned claims.

Example: The reasonable charge for a covered service is $100 and the deductible has been satisfied. If the claim was assigned, your payment of $80 will be reduced by 2.092 percent or $1.67 and a payment of $78.33 made. The beneficiary is responsible for 20 percent of the reasonable charge or $20. The physician or supplier may not charge the beneficiary for the amount of the reduction. If assignment was not accepted, the beneficiary is responsible for the full charge or $100 and the program makes a payment of $78.33 to the beneficiary.

- Participating physicians and suppliers continue to be required to take assignment for all covered services.
- This provision will not affect subsequent updates to reasonable charges, i.e., the provision reduces program payments and does not change the procedures for determining customary and prevailing charges.

ANESTHESIA CROSSWALK UPDATE

Surgical Code	Anesthesia Code	Uniform Base Unit	Surgical Code	Anesthesia Code	Uniform Base Unit
22222	00620	10	35585	01270	8
22224	00630	8	35587	01270	8
23430	01716	5	35621	01656	10
24900	01756	6	35721	01270	8
25446	01832	6	36810	01844	6
27454	01230	6	36815	01844	6
27612	01470	3	36820	01844	6
33201	00520	6	38510	00320	6
34101	00350	10	38520	00320	6
35001	00350	10	49500	00830	4
35002	00350	10	49505	00830	4
35301	00350	10	49550	00830	4
35381	01440	5	57300	00902	4
35582	01270	8	65815	00140	5
35583	01270	8			

1990 PARTICIPATION INFORMATION

The Congress is currently considering legislation which would affect 1990 payment levels for physicians and suppliers. The Health Care Financing Administration has advised carriers that among the provisions under consideration is one which delays the 1990 enrollment in the participating physician/supplier program from January 1, 1990 to April 1, 1990. We will, of course, inform you of the legislative changes and of the procedures for enrolling in the participating physician/supplier program as soon as the outcome of the legislation is known. However, you can terminate the agreement effective January 1, 1990. If that is your decision, you must notify every Medicare carrier with whom you filed a participation agreement or a copy of the agreement that you wish to terminate. Your request(s) must be postmarked by December 31, 1989, and addressed to Medicare B, Provider Unit, P. O. Box 994, Marion, IL 62959. No fee screen data is being released at this time. The expectation is that 1990 screens will not go into effect until April 1, 1990 and that 1989 screens will remain in effect until that time.

(This report is a service to the physicians of Illinois)
12/08/89

Editorials

Year-end resolutions and deadlines

Now is the time for ISMS members to think about year-end tasks. Those physicians affected by the Clinical Lab Act or service occupation tax regulations need to make sure they comply, as the deadlines for both arrive with the new year. ISMS suggests members should also consider paying their membership dues before year's end, in order to take advantage of favorable tax treatments.

Midwives and the obstetrical care puzzle

The context is clear enough: there is a clear shortage of obstetrical care services in rural Illinois, particularly in the southern part of the state. At the same time, various groups of non-physicians have been knocking at the door of professional acceptance, seeking licensing for the independent delivery of health care services.

Now a group of lay midwives—individuals without medical training who sometimes work without physician supervision—are suing state agencies for professional recognition. This suit comes in the wake of criminal charges against some of them for practicing medicine without a license—charges which were dropped in exchange for initiating the civil suit to clarify their status.

The Illinois State Medical Society (ISMS) is clear on this point. While ISMS supports the physician-supervised work of licensed, qualified allied health care professionals, it strongly opposes the practice of medicine by those who are not licensed to do so. We hope the court reviewing this case will keep the safety of patients in mind, and decide to maintain the highest standards in the delivery of medical care.

Physician billing and those gray areas

To begin with, let's keep in mind that the vast majority of physicians are honest, according to the investigators looking into questionable billing practices.

So rather than actual fraud, investigators are turning to those gray areas of billing, especially that of deliberate multiple service pricing, or "unbundling." Doctors should be aware that unbundling has become a high-profile issue among payors, and should review their billing practices to make sure they're comfortable with them, particularly if they don't assign codes themselves.

It is too easy to assume that physicians will be given the benefit of the doubt when questions arise. Unfortunately, they may not be. In this case, the old adage rings true: prevention is a lot better than a "cure." ▲

Illinois Medicine

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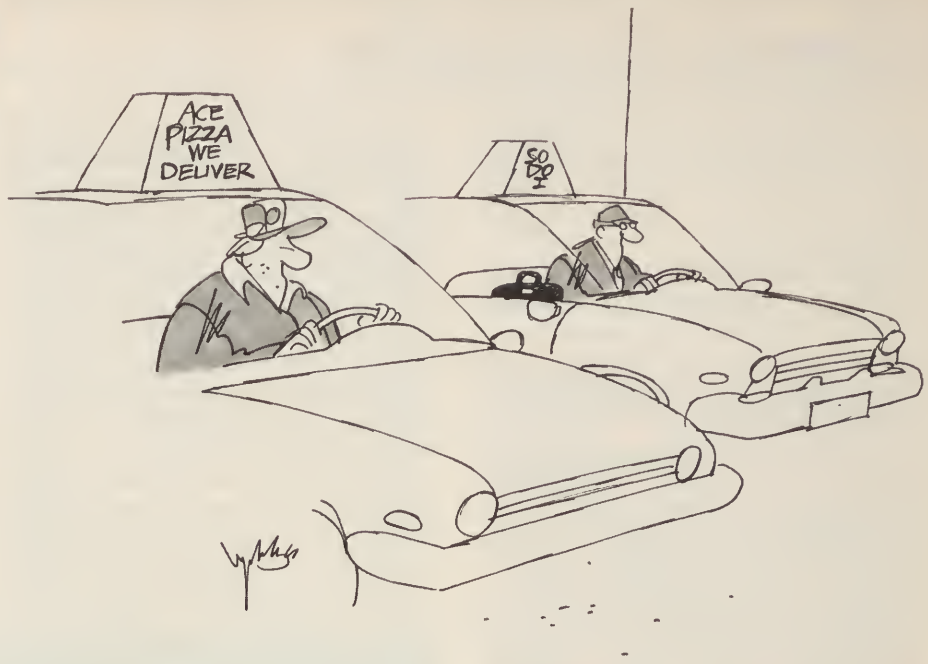
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President's Column

All for one and one for all



Eugene P. Johnson, M.D.

One of my most important duties as ISMS president is to bring our members and the public the ISMS message through the President's Tour. This pilgrimage through Illinois takes place annually; during my fall sprint across the state, I have been stressing themes I believe are critical to the future of our organization: unity, participation and commitment.

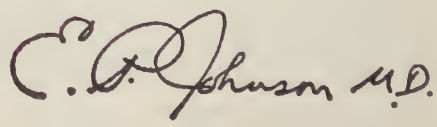
As I have been telling physicians from DeKalb to Carbondale, we as a medical society need to hear the active voices and input of every single physician in Illinois in order to represent medicine effectively. ISMS is a mirror of the policies laid down by our 400-member House of Delegates, which represents you, the individual practicing physicians of this state.

At a time when legislatures at all levels of government, judges in every court, and administrators in every type of bureaucracy are reaching out to extend ever-greater control over the practice of medicine, only a strongly unified voice can carry the concerns of physicians to the ears of decisionmakers. What you as medical professionals know is right and desirable may not come across clearly amid the din of contested views. In this atmosphere, even minor differences inside the house of medicine can appear to echo resoundingly outside.

Secondly, your participation is needed in order to combat the manifold misperceptions of physicians in the nonmedical community. To cite just one example, we learned recently through focus groups that Illinois senior citizens long for perspective and guidance from the doctors who treat them, and whom they trust. But government leaders have in some cases cut back on benefits to seniors while making physicians look like the "bad guys." We need to make sure more information is put forward to combat such misperceptions.

Finally, only sincere commitment on the part of all of us can bring us success in our efforts. A story I particularly like to tell my audiences is one about Albert Einstein, the renowned physicist and humanitarian. As a child, Einstein's parents were very worried about his intelligence: at nearly three years of age he had not spoken a single word. They actually feared he was retarded. Finally, at the supper table one night, he broke his silence to state clearly, "The soup is too hot." His parents, greatly relieved, asked him why he had never before spoken. Einstein replied, "Because up to now, everything was in order."

We, like young Albert, can look back on a time when physicians were not besieged by government interference, rampant cost-cutting, malpractice jeopardy and waning prestige. And like him, we know now that not everything is in order. Let us take action while the moment calls for it. With your participation and support, we are bound to be heard. ▲



Eugene P. Johnson, M.D.
President

Guest Editorial

A physician looks at the Canadian and American health care systems

by Hugh Scully, M.D.



With the inflation rate for health care in the United States rising every year at more than twice the rate of inflation, the phrase "Look North" has become a rallying cry for some Americans.

A spate of documentaries, news reports and studies has made many in the U.S. aware of the alternative system to the north, though not necessarily in detail or with full comprehension.

Hugh Scully, M.D., chairman of the Council on Medical Economics of the Canadian Medical Association (CMA) and past president of the Ontario Medical Association (OMA), a member of the Ontario Premier's Council on Health Strategy, and Deputy Surgeon of Toronto General Hospital, told attendees at the Illinois State Medical Society All-Member Conference on November 18 that Canada and the United States both have valuable insights to share with one another when it comes to health care policy issues. Below are excerpts from Dr. Scully's speech:

I don't believe one can transpose the health care system of one country to another country; every country has its own culture. But every country has some things that may be of value to another.

The United States and Canada have many, many things in common. We have the same education system, often with reciprocity. In terms of health care, Canada's is a more conservative, state-sponsored health care system.

Now, before I get into details about some aspects of the Canadian system and differences between ours and the American health care delivery system, let me state that the real determinants of health are usually wealth, public policy and the individual choices we make.

Pluses and minuses

Canada is struggling with some of the same questions as is the United States. We, too, have too many physicians, and have maldistribution of medical care.

And the rate of increase of medical malpractice is high in both countries. In fact, in recent years, the Canadian rate has been 200-300 percent what you've had here.

Your U.S. representative [Lynn Martin see story on page 12] made some very pertinent points in her address yesterday evening. She's right when she says 'Some of the best in medicine are in the United States.' I would add, however, that there are many who cannot afford the quality you have.

The United States is currently spending 11.4 percent of its gross national product (GNP) on health care,—and that percentage is continuing to rise—while Canada is spending 8.6 percent for the past three years. Most Western industrialized countries are holding the line at between 7 and 9 percent.

On a per capita basis, Canada is spending $1200 per citizen on health care, while the US is spending $1700-$1800 per citizen—and even then, 39 million Americans have no coverage, while 100 million are on the verge of having no coverage!

But a negative consequence of Canada's universal health care availability is debt. In Canada, 37 cents on every dollar goes to service the national debt. Then, there is added provincial debt; in Ontario, it's another 5 cents. So you have 42 cents or more in most provinces as debt service.

As a consequence, provincial governments in Canada are trying not only to hold the line on health care spending, but actually to reduce the percentage of their budget on that expense.

A history of public initiatives

The history of our system is thus. In the 1920s and 1930s, provincial governments began discussing public funding of health care. In 1947, Saskatchewan became the first province to introduce public hospitalization insurance, which gradually expanded into a broader array of financed services, culminating in the federalization of our system in 1971.

Now, some of the articles which have been written on the Canadian health care system have implied that the federalization of the system led to cuts in physician payments. It's true that it is now illegal for any doctor to charge more, or for any patient to pay more, than government-negotiated rates. But the fact is, only five percent of doctors were charging more before that clause went into effect in 1982 anyway.

Also, in some ways, we have more freedom than you do in the U.S., in terms of how we can administer care.

The Canadian health care system is founded on five principles: public administration, universality, accessibility, portability, and comprehensiveness.

First, in terms of public administration, it's true we're talking about a government bureaucracy. But the fact is, we spend less than 0.1 percent of our GNP on health care administration, while you in the U.S. are now spending between 0.6 and 0.8 percent of your GNP. One reason is perhaps that we've got better political accountability; we have line accountability for administration.

Regarding accessibility, it's true that the question of what constitutes 'reasonable accessibility,' our defined goal, is a problematic one. The U.S. press has noted that we send some CT scans and coronary bypass surgeries to the U.S., as we have long waits for those procedures. While I believe there is a technology lag in Canada for some of these procedures, I should add that you in the U.S. have far too many coronary bypass centers and far too many CT scanners than are necessary.

Portability is a tremendous benefit of our system. Canadians have access to our health system wherever they go. They're not locked into their provincial systems. They're covered for all illness anywhere.

Comprehensiveness is another advantage. We have comprehensive programs for breast screening, cholesterol screening, long-term monitoring, and the like.

Doctors not fleeing

One other myth that has been spread through press accounts in the U.S. is that we in Canada have lost tremendous numbers of physicians. It is not the case that there has been a mass exodus of Canadian physicians elsewhere. At the top level, I have a concern that we're losing some physicians and surgeons to the U.S., but there's been no net emigration of Canadian doctors.

Right now, 90 percent of Canadian physicians are paid on a fee-for-service basis, and the remainder are paid through capitation or salary. There's been more interest evolving in capitation and salary. My own view is that the best system is a blend of these approaches.

What has happened to fees? Well, 16.5 percent of health care expenditures currently go to physician payments in Canada, versus 19.5 percent in the U.S. MDs are not underpaid in Canada.

One problem we do have is that the system gives no recognition to regional cost differentials, something you've already achieved through your payment systems.

But just a quick glance at a few procedures will show significant cost differences between American and Canadian charges. A triple aorta coronary with LIMA assessment in Canada, for instance, is charged at the rate of $1400 (U.S.$), while in the U.S., it tends to run in the $4000-$5000 range. And a bentall procedure costs $2000, as opposed to $10,000 in the U.S. While I believe some of Canadian fees are too low, I believe $10,000 is simply too much for that procedure.

Unified voices

Finally, I would like to say to my colleagues in the U.S. that unity with a reasonable voice is a potent force in politics. In Canada, we've been able to speak with a degree of unity. And the degree of understanding has been remarkable when government leaders and physicians have gotten together publicly to discuss our system.

I don't think either system is the best it can be, or is significantly better than the other. Let's remember that we can make improvements in every system, and can share insights to improve health care in all countries. ▲

Letters to the Editor

Champaign hospitals' merger: a clarification on abortion

I would like to clarify two correctly quoted but potentially misleading remarks attributed to me in your November 10th article "Champaign hospitals merger now complete."

The bylaws of Covenant Medical Center, like those of its predecessor institution, Mercy Hospital, require *strict* adherence to the *Ethical and Religious Directives for Catholic Health Facilities.* No abortions, defined in this document as "the directly intended termination of pregnancy before viability . . . (or) the directly intended destruction of a viable fetus" were performed at Mercy or will be permitted at Covenant. However, in keeping with the *Directives,* certain specific procedures *are* permitted even though they "may or will result in the death of the fetus." Included here are several procedures, among them "operations, treatments and medications, which do not directly intend termination of pregnancy but which have as their purpose the cure of a proportionately serious pathological condition of the mother. . . ."

My remarks to the author were intended to convey this meaning but were unfortunately imprecise. I regret any misunderstandings that may have occurred as a result.

Stuart W. Fulks
Vice President for Marketing
ServantCor

Kudos for your courage

As chairman of the Cult Awareness Network Committee on Ritual Abuse, I applaud *Illinois Medicine* for publishing the November 10 article "Ritual child abuse and satanic cults: a growing menace." It is an accurate and timely article.

We are very concerned about satanic/ritual abuse injuries, as alluded to in the article, since crimes committed under the guise of the first amendment by destructive cult groups are increasing within our society, and it has become a problem for law enforcement, the medical community, educators and concerned citizens.

Bette Naysmith, M.P.A.
Chairman, Cult Awareness Network
Committee on Ritual Abuse

ISMIE's risk management group looks at sterilization claims

IN RECENT months, the Risk Management Committee of the Illinois State Medical Inter-Insurance Exchange (ISMIE) has stepped up efforts to identify and address the causes of medical liability claims.

"Rather than deal with losses only after they occur, we are also starting at the beginning to find out why the claims arise, in order to prevent future incidents," says Jere E. Freidheim, M.D., a Chicago pediatrician and the committee's chairman.

A tangible example of this philosophy is the work product of the recently-formed Risk Management Subcommittee on Obstetrics and Gynecology. An analysis of claims involving sterilization procedures by this subcommittee has produced valuable insights that could minimize the incidence of such suits.

"When our subcommittee was organized recently, we wanted to select and study those areas of obstetrical and gynecological practice producing the largest number of, or the most costly claims. Tubal sterilization is the second most common procedure in this field of medicine generating ISMIE claims and the sixth most costly. The average indemnity for sterilization-related cases is $76,945," says M. LeRoy Sprang, M.D., a board-certified Evanston OB/GYN and surgeon who chairs the subcommittee.

Dr. Sprang notes that the subcommittee targeted sterilization for its initial study because it was a well-defined area involving straightforward procedures.

"Most claims arise from failed tubal sterilizations and from complications, such as bowel or bladder injuries, or infection, with many claims also alleging failure to obtain informed consent," he says.

Based on its review and discussion of actual ISMIE closed claims, the subcommittee has developed a number of suggestions for physicians performing sterilization procedures:

- Explain the possible methods of sterilization fully to a patient in advance of the procedure and discuss the advantages and disadvantages of the various treatment options. The American College of Obstetrics and Gynecology (ACOG) has printed patient information booklets to supplement information discussed with patients.
- Make it clear that any sterilization procedure is *intended* to be permanent and that it will be very difficult, if not impossible, to restore the ability to conceive in the future.
- Emphasize that sterilization, like any other method of birth control, is not 100 percent effective. Pregnancy can sometimes occur afterwards. Don't make any guarantees that a patient will not become pregnant. If a percentage risk of failure of the procedure chosen is known, it is advisable to provide this information to the patient.
- Describe potential risks and complications, including possible injury to the bowel, bladder or other organs, and infection.
- Document the informed consent discussion and obtain a signed consent form from the patient and file it with the chart.
- Make every effort to ascertain whether the patient might be pregnant at the time the procedure is to be done. You may avoid this possibility by scheduling the procedure early in the cycle (within 14 days of period onset). Recommend effective birth control measures prior to the procedure and when any question exists, document with Hcg testing.
- Send any specimens obtained from both fallopian tubes to the pathology laboratory for study after the procedure is completed. Obtain and read the pathology report.
- When laparoscopic techniques are used, document occlusion of both tubes by use of video recording or chromotubation techniques.
- Instruct the patient to report any post-procedure problems that could indicate complications, such as pain or bleeding. Written patient instructions with documentation of information provided are advised.
- Appropriate patient selection and written discharge instructions are important in procedures performed on an outpatient basis.
- If a complication does occur, treat it immediately. The response or lack of response to complications caused many of the claims reviewed, not the complication itself.
- Unusual problems or complications, or variations in the technique required during the procedure, should be documented in detail. A factual account of problems like adhesions has eliminated much of the "second guessing" that occurred in the cases reviewed.

"Many of the women who conceive after the procedure will go to another physician because they are angry that they became pregnant despite the sterilization procedure. So it becomes extremely important how the second physician handles the encounter. If the second physician says, 'I would have done a different procedure,' the patient construes this statement to mean that the first doctor did something wrong. That can send a patient to a plaintiff's attorney," Dr. Sprang says.

Ironically, a few of the patients who eventually sued for a failed tubal ligation were already pregnant at the time the procedure was done, reports Dr. Sprang. "The problem is that some patients may be in the very early stages of pregnancy when it is not easy to detect."

The subcommittee will examine claims associated with hysterectomies next and is scheduled to do a major assessment of the broad topic of pregnancy and related suits.

Dr. Freidheim also reports that a second risk management subcommittee, this one on orthopedics, is also at work and future specialty subcommittees are planned. The full Risk Management Committee is composed of a variety of medical specialists. ▲

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

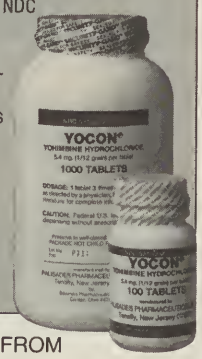
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ISMIE annual meeting set for April 4: nominations sought

THE Illinois State Medical Inter-Insurance Exchange (ISMIE) will hold its annual meeting on Wednesday, April 4, 1990 at 4:00 p.m. at the Westin O'Hare Hotel. At that time, members of the Exchange's Board of Governors will be elected. Members of the board shall be elected by a majority vote of the members represented at the annual meeting in person or by proxy.

The Board of Governors has general supervision over the finances and operations of the Exchange, and establishes all policies governing the proper transaction and conduct of the business and affairs of the Exchange.

Any member of the Exchange interested in serving as a governor should so notify, in writing, Fred Z. White, M.D., chairman, Board of Governors, Illinois State Medical Inter-Insurance Exchange, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. Please include a current curriculum vitae. All letters of intent received at the Exchange office *on or before January 5, 1990* will be considered by the nominating committee. ▲

Obituaries

** indicates ISMS member*
*** indicates member of ISMS Fifty Year Club*

***Baab**
Oren D. Baab, M.D., of Hinsdale, died April 12, 1989 at the age of 74. Dr. Baab was a 1943 graduate of Northwestern University Medical School, Chicago.

****Bothe**
Russell T. Bothe, M.D., of Solana Beach, California (formerly of Aurora), died March 26, 1989 at the age of 86. Dr. Bothe was a 1934 graduate of Northwestern University Medical School, Chicago.

Cruzat
Roscoe Cruzat, M.D., of Chicago, died May 18, 1989 at the age of 98. Dr. Cruzat was a 1924 graduate of Chicago Medical School.

Goldberg
Leon Goldberg, M.D., of Chicago, died May 8, 1989 at the age of 62. Dr. Goldberg was a 1956 graduate of Harvard Medical School, Boston, Massachusetts.

***Kaplitz**
Sherman E. Kaplitz, M.D., of Wilmette, died May 20, 1989 at the age of 70. Dr. Kaplitz was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

Kenward
John Kenward, M.D., of Chicago, died April 3, 1989 at the age of 75. Dr. Kenward was a 1944 graduate of the Pritzker School of Medicine, University of Chicago.

****Kushner**
Abraham Kushner, of Palm Beach, Florida (formerly of Chicago), died March 24, 1989 at the age of 79. Dr. Kushner was a 1934 graduate of Chicago Medical School.

***Matheson**
Harl Matheson, M.D., of Princeton, died April 9, 1989 at the age of 75. Dr. Matheson was a 1943 graduate of Washington University School of Medicine, St. Louis, Missouri.

***Murray**
John C. Murray, M.D., of Chicago, died May 9, 1989 at the age of 91. Dr. Murray was a 1926 graduate of the Northwestern University School of Medicine, Chicago.

****Page**
Manley A. Page, M.D., of Sand Lake, Wisconsin (formerly of Chicago), died March 27, 1989 at the age of 90. Dr. Page was a 1926 graduate of Northwestern University Medical School, Chicago.

****Raider**
Joseph Raider, M.D., of Mundelein, died March 25, 1989 at the age of 80. Dr. Raider was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

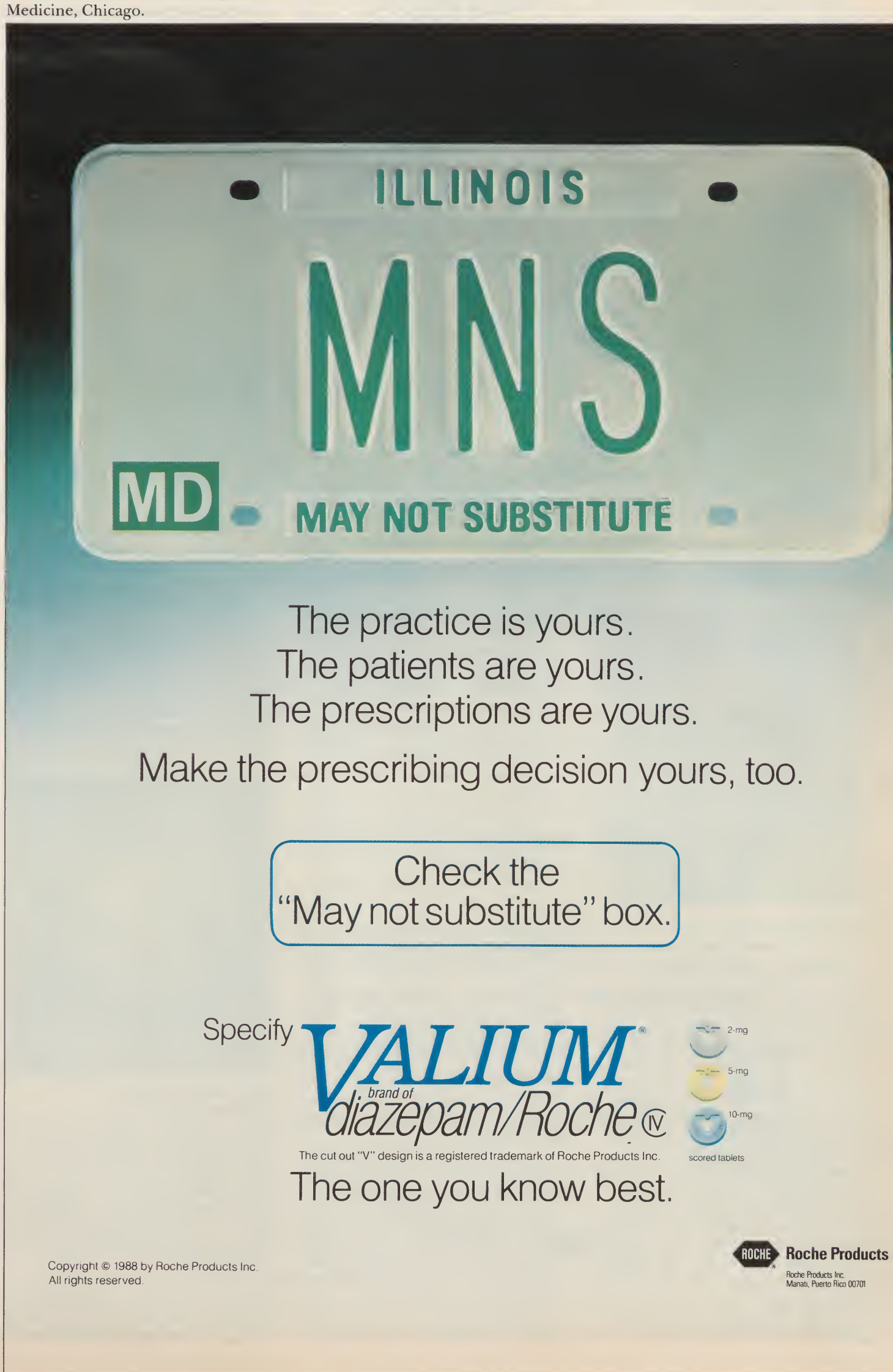
****Seifert**
William F. Seifert, M.D., of El Toro, California (formerly of Rockford), died May 13, 1989 at the age of 77. Dr. Seifert was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

****Tavenner**
John Tavenner, M.D., of Dixon, died April 22, 1989 at the age of 85. Dr. Tavenner was a 1930 graduate of Northwestern University Medical School, Chicago.

****Tootson**
Edward O. Tootson, M.D., of St. Petersburg, Florida (formerly of Carpentersville), died March 30, 1989 at the age of 76. Dr. Tootson was a 1938 graduate of Tartu Ulikooli Faculte de Medecine de l'Universite de Tartu, Tartu, Estonia.

****Warner**
Harry Warner, M.D., of Pagosa Springs, Colorado, (formerly of Rockford), died April 4, 1989 at the age of 89. Dr. Warner was a 1926 graduate of the University of Minnesota Medical School, Minneapolis.

***Wright**
Theodore S. Wright, M.D., of River Forest, died April 28, 1989 at the age of 77. Dr. Wright was a 1942 graduate of Chicago Medical School.



Second part in a series

The Big Empty: coping with the downstate doctor crisis

by Mary Delach Leonard



Don Marquis

ALAN Hoffman, M.D., an obstetrician-gynecologist in Vandalia, quit delivering babies last year because he had no backup. When an associate left in 1987, he became Fayette County's only obstetrician. After a year of being constantly on call, Dr. Hoffman says he was exhausted.

"I tried to do it myself for one year," says Dr. Hoffman. "But it took all the fun out of it."

Dr. Hoffman is far from alone in his plight: across rural Illinois, physicians are faced with manpower shortages and recruiting difficulties.

"The biggest problem is getting good people out here who are willing to spend the time and enjoy the lifestyle that is available," says Merle Muller, M.D., a family practitioner in Fairfield.

The problems are many. Low Medicaid reimbursement levels for rural physicians, the state's current malpractice climate, and the decline of rural hospitals are in themselves major obstacles, say rural physicians. And these problems in turn exacerbate the basic problem of the physician shortage.

"A lot of times, young physicians are drawn to urban areas because of the potential for a lot of the newer equipment, specialty and sub-specialty consultation and urban amenities such as sports and concerts," says Dr. Muller. "Also, in rural areas, the hours you work are longer, and your reimbursement is less."



Alan Hoffman, M.D., of Vandalia

Problems are of long standing

The problems in recruiting rural physicians aren't new, says Jack Gibbs, M.D., a surgeon who has practiced in Canton since 1965. "We suffer from a continuing manpower shortage in most rural communities," said Dr. Gibbs. "So physicians who go to the rural communities are often overworked and underpaid."

Because of the declining economies of many rural areas, a larger percentage of patients are self-pay or on public aid. Fees are less, but expenses are as high for rural doctors as they are for urban doctors, says Dr. Gibbs, who is the chairman of the Illinois State Medical Society-Illinois Agricultural Association (ISMS-IAA) student loan fund program. And, Dr. Gibbs adds, the problems of small hospitals must be recognized, because viable hospitals are needed to attract physicians.

"People coming out of residencies today, says Dr. Gibbs, want to make sure they can practice medicine in the way they have become accustomed to practicing—having specialty support and technology. As small hospitals continue to have their patient base erode, they can't keep up with the physicians' demands."

Rural hospitals are competing not only with urban hospitals, but with other rurals as well in attracting physicians, says Jack Martin, administrator of Fairfield Memorial Hospital. Martin's 79-bed hospital recently recruited a married couple—an internist and an anesthesiologist—but needs at least two more physicians.

"I hear some people say they want to be in a rural area—a town of 25,000 people, 15 minutes from a metropolitan area. We're 70 miles from Evansville, Indiana, and 110 miles from St. Louis. There's rural and then there's *rural*," he says.

The hospital responded to the departure of four young physicians by meeting demands of the remaining doctors, including providing 24-hour emergency room coverage so that doctors weren't constantly on call. And the hospital worked with the community to raise funds for a CT scanner, mammography and ultrasound equipment.

"Rural hospitals must respond to assure the doctors they're going to get some relief," says Martin, "that they're going to have support service. They're going to have the on-site equipment or its availability. These will provide a comfort level for the doctors—the knowledge that they will have colleagues and not be on an island by themselves," says Martin.

The spouse factor

Attracting physicians to rural areas also means attracting and satisfying their spouses.

"I can sell a physician on our opportunities here very easily. But if you don't sell the spouse, the spouse is not going to be happy and then you're not going to retain the physician," says Dr. Muller.

Physicians with rural backgrounds find it easier to return to rural areas to practice and are less likely to leave the area when their loan commitments are fulfilled, says Dr. Gibbs.

"Our particular loan fund program has tried to solve the problem by identifying people whose backgrounds and motivations would suit a small-town practice and help them go back to a small community," he says.

What medical schools can do

Medical schools can help by taking a more positive attitude about rural medicine, says Larry Jennings, M.D., a Mt. Carmel internist.

"We need to work hard at encouraging good qualified people to practice in rural communities and we need to think positively about it," he says. "Yes, people in Wabash County or Hamilton County are just as important to our economy and to our lifestyle as people who live in Cook County. Without the farmers, the people in Cook County would be very hungry. You can't do a lot of farming on the Magnificent Mile."

The high cost of medical school is another reason physicians choose urban settings to begin their practices, says Mary Markle, M.D., a Centralia obstetrician-gynecologist.

"When they come out of school, they owe a lot of money," says Dr. Markle. "They like to be in a big group where they can be salaried and their educational debts can be paid off without risk."

Rural physicians say recent Medicaid increases will help, but are only the beginning of many changes that must be made to improve health care.

Rural doctors agree that tort reform, including a cap on non-economic damages, is necessary to stop the migration of doctors across state borders.

"If you look at the east side of our state—it is riddled with empty doctor's offices. Just think of the money going to Indiana. Illinois is losing out," says Dr. Hoffman, who is a member of Lieutenant Governor George Ryan's rural health task force.

Dr. Hoffman says his highest priority on the task force has been malpractice reform.

"I'm not sure we can do much more at the state level. The federal government has to—at some point—put up or shut up," says Dr. Hoffman. "If they are interested in improving medical care in rural areas, things have to be done at the federal level. I think there needs to be federal malpractice legislation. And if anything is to be done about Medicare, that has to be done at the federal level."



Mary Markle, M.D., of Centralia

Dr. Hoffman was the first obstetrician in Fayette County when he began his practice in 1980. The local hospital closed its OB unit when he stopped delivering. Women in that county are now served by obstetricians in three surrounding counties. Dr. Hoffman said he would consider delivering babies again if he had backup and if some changes occur, particularly in malpractice.

He adds, the task force has made good suggestions regarding rural health, but the question of funding remains the overriding factor, warning that because of budgetary restraints at the state and federal level, it is going to be a long, hard battle.

"More people are demanding the best health care, but nobody wants to pay for it—not the government, the insurance companies or individuals," says Dr. Hoffman.

Rural physicians say that much attention has been focused on their problems, but they have seen few results.

"I think everybody wants to solve the problem. I think that given the money, the problem would be solved.



Merle Muller, M.D., of Fairfield

But the money is not there," says Roger Klam, M.D., a Carbondale OB/GYN.

Dr. Klam notes rural physicians also face problems caused by state rules and regulations designed to solve problems in Chicago. "There are two areas in Illinois—Chicago and not-Chicago. And Chicago tends to dominate," he says.

Illinois Lieutenant Governor George H. Ryan's task force on rural health is scheduled to be released by January 1, 1990, doctors note.

Benefits, too

Robert Einhorn, M.D., an Olney pediatrician, believes that while the focus tends to be on problems associated with rural practice, there are also benefits and that word needs to be spread about opportunities that are available in both group and individual practice. "There is the opportunity to practice medicine at a high level—with colleagues. I haven't found isolation to be the case," he says, adding that for him, rural practice provides a busy, but rewarding lifestyle.

"If there is a message that we need to get out, it's that it is a good lifestyle," he says. "It's not all problems, but we need to address the problems as they arise." ▲

News Capsules

Members in the news

Walter W. Whisler, M.D., Ph.D., vice-chairman of the board of governors for the Illinois State Medical Inter-Insurance Exchange (ISMIE) has been elected president of the medical staff at Rush Presbyterian St. Luke's Medical Center in Chicago and an annual trustee of the medical center's board. . . . **Frank L. Hussey, Jr., M.D.**, of Wilmette, was named vice-president of the American College of Radiology (ACR) for 1990-91 during the ACR annual meeting in Seattle,WA. Dr. Hussey, who is a clinical assistant professor of radiology at the University of Illinois in Chicago and has served on the staff of the Fermilab Cancer Treatment Center in Batavia, is currently an attending radiation oncologist at Lutheran General Hospital, Park Ridge, and the Elk Grove Cancer Center, Elk Grove. . . . **Daniel Murphy, M.D.**, of Evanston, was appointed chairman of the department of radiology at St. Francis Hospital, Evanston. Dr. Murphy has been on the hospital staff since 1960. . . . **Jose Luis Salazar, M.D.**, of Dundee, was recently appointed chairman of the section of neurosurgery at Illinois Masonic Medical Center, Chicago. Joining the Illinois Masonic medical staff in 1972, Dr. Salazar has served as its secretary and later president. He is an associate professor of neurological surgery at the University of Illinois Abraham Lincoln School of Medicine, where he has been director of teaching and research for the microneurology laboratory. . . . **Henry W. Wiggins, Jr., M.D.**, of Chicago, has been elected president of the medical staff of St. Bernard Hospital, and was re-elected chairman of radiology, a position he has held since joining the medical staff in 1973. . . . The American College of Emergency Physicians (ACEP) has announced the election of **Robert K. Anzinger, M.D.**, of River Forest, to the position of president of the board of directors. Dr. Anzinger is currently president of DuPage Emergency Physicians, Lombard, and chairman of the department of emergency medicine at Good Samaritan Hospital, Downers Grove. He joined ACEP in 1973 and served on its national board of directors from 1978-81 and since 1986. . . . **Barry H. Weber, M.D.**, of Highland Park, has been appointed director of the division of neurology at Lutheran General Hospital, Park Ridge. Dr. Weber has been on the Lutheran General staff since 1977.

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- ☐ Advances in Pediatrics, 1990
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- ☐ Advances in Family Medicine, 1990
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- ☐ General Surgery Update: 1990 (The Cloister, Sea Island, Ga.)
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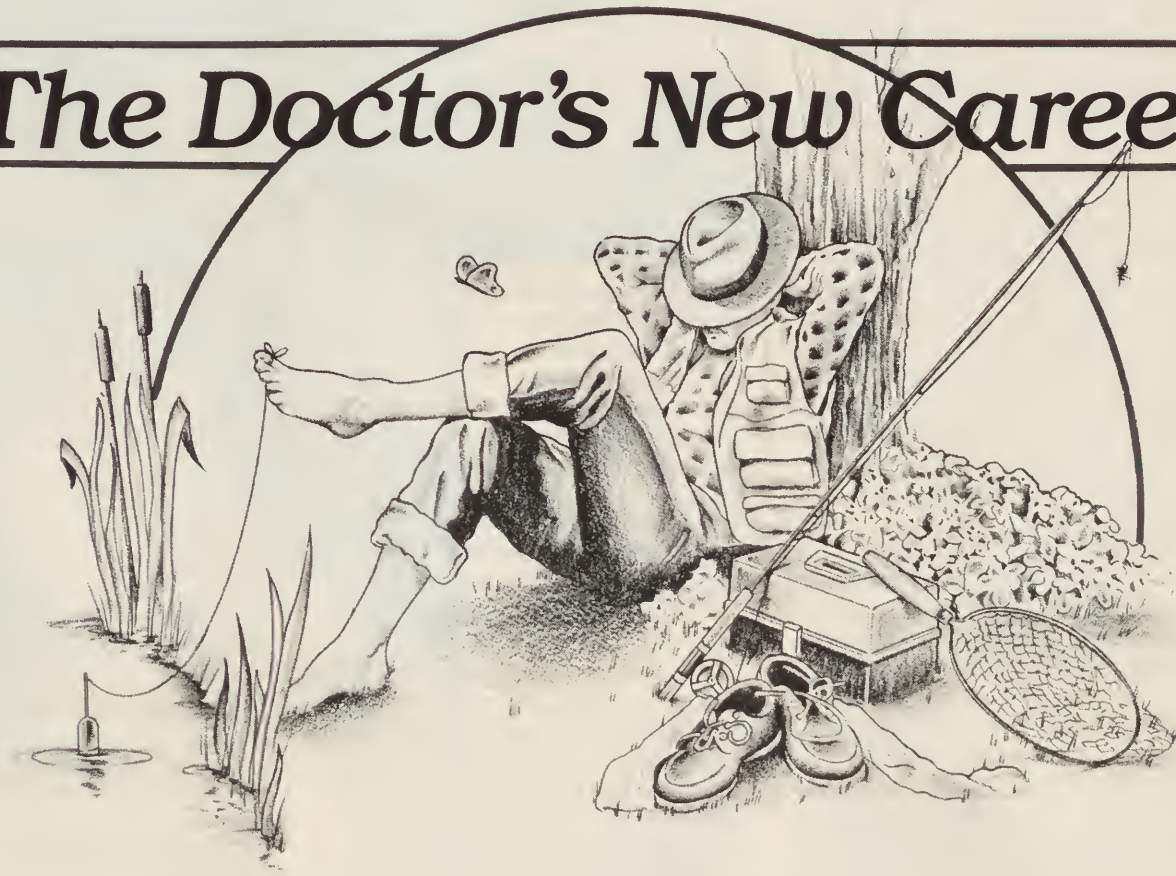
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Health care professionals increase awareness of Hispanics' needs

BY THE YEAR 2000, according to the U.S. Census Bureau's highest estimates, the nation's Hispanic population is expected to double. In Chicago, Hispanics (a term used loosely to refer to Mexicans, Puerto Ricans, Cubans, Central Americans and other Spanish-speaking Latin Americans living in the United States) will make up 20 percent of the city's population by next year, according to the Latino Institute. But local researchers have just begun in the last decade to assess in an organized way the health care status of this population identified by many as "in crisis."

While the nation's total population has increased seven percent since 1980, the Hispanic population has grown 34 percent, with the heaviest concentrations in California, Texas, New York, Florida and Illinois, according to the U.S. Department of Commerce. Four percent of the nation's total Hispanic population live in Illinois.

Inherent in this growing population is an expanding menu of illnesses and health care problems, including some of the highest rates of diabetes, hypertension and infant mortality. Those who have studied Hispanics' medical care in Chicago say the causes are many and profound. They agree that major contributing factors to the illnesses Hispanics face include poverty, lack of education and cultural differences.



Top: Father Michael Michelini of St. Aloysius Church and board member of St. Elizabeth's Hospital, Chicago. Center and bottom: Patients receive care at St. Elizabeth's. (Photos courtesy of St. Elizabeth's Hospital, Chicago.)

Understanding the culture

"We don't expect half the physician force to be Hispanic or bilingual, but with this population growth comes a need for physicians to have a good understanding of the Hispanic culture, barriers and certain health problems prevalent in the culture," says Manthani Reedy, M.D., medical director of South Lawndale Health Center, an affiliate of Cook County Hospital which treats some 28,000 Hispanic patients a year. "Knowledge about where Hispanics are coming from can assist physicians in what to look for when they're taking, for example, a patient's history," he says.

"This ethnic group is very receptive to medical care. When a doctor tells them to do this or that, they do it. But when physicians cannot understand them, both in culture and language, it creates feelings of frustration and alienation," adds Dr. Reedy.

In 1981, an organization now known as the Hispanic Health Alliance issued one of the first reports assessing Hispanic health care needs in Chicago. Octavio Mateo, the group's former vice-chairman, says the report initiated studies of Chicago's Hispanic population, including "Project Alivio" (*alivio* means "wellness" in Spanish), a local study that supported what national researchers claim to be a major problem among Hispanics nationwide: access to and financing for health care.

"Health care is not a high priority among Hispanics because of the high cost," says Father Michael Michelini. Father Michelini is pastor of Saint Aloysius Church and a five-year member of the board of directors at St. Elizabeth's Hospital, both in the predominantly Mexican and Puerto Rican Wicker Park neighborhood on Chicago's northwest side. "Many Hispanics work in places like factories and shoe stores where they don't get health insurance," says Father Michelini. "They are stuck between the cracks, between those people who qualify for welfare and those who can afford to pay for health care—in other words, above the poverty line and ineligible for Medicaid."

Nationally, nearly one-third of U.S. Hispanics have no health insurance coverage. Forty-six percent are covered under employment-related private insurance, and only 18 percent are covered by Medicaid or other public programs, according to the National Center for Health Services Research and Health Care Technology Assessment.

"Project Alivio" reports non-coverage

In Chicago, 300 households from three of the most heavily populated Hispanic communities were surveyed during 1987 for Project Alivio. The targeted neighborhoods were the city's lower west side, South Lawndale and Back of the Yards (New City) areas. The survey found an alarming rate of non-insurance and under-insurance in Hispanic communities. Statistically, 44 percent of respondents had no medical insurance. Of the uninsured, 14 percent had previously been covered, but were no longer insured, while 27 percent had never been insured. Of insured respondents, 55 percent were insured through their place of work, while Medicaid and Medicare accounted for four percent each.

"Of the respondents who are [now] or had at one time been insured, one in four had insurance only for themselves, not for their family," says Anna M. Lopez, an author of Project Alivio. "As was suspected, a greater proportion of male respondents are insured without the entire family even though it is more likely that women and children would need coverage most. Thirty-three percent of male respondents had insurance only for themselves, as opposed to 20 percent of female respondents," says Lopez.

The report also specified that only 39 percent had used medical insurance in the last 12 months, implying that well over 61 percent of the sample were insured persons who had not used their health coverage. When asked to speculate about their coverage by medical insurance twelve months from now, 62 percent anticipated being covered, 20 percent said they would most likely not be covered. Fifteen percent said they did not know, according to the report.

Changing cultures raises barriers

"Hispanics start off with a language barrier. Added to that is their immigrant family status, which is often one of transition. They must adapt to another culture, after utilizing a different sort of health care," says Louis Fourcher, Ph.D., executive director of Erie Family Health Center in West Town, where 85 percent of the patients are Hispanic. "These problems," says Dr. Fourcher, "along with poverty are elements that add up to difficulty in gaining access and knowing how to use the health care system in this country."

"Workers in some other western hemisphere countries are covered under a national health service," notes Michael Fisher, M.D., of the Erie Family Health Center. Dr. Fisher also holds a master's degree in public health. "In Mexico, for example, you can be a very poor worker and still have health insurance through the federal government. Because they can't speak English well and lack education, many of the jobs immigrants take in this country are not accompanied by health insurance," Dr. Fisher says.

"If people don't have health insurance, they're going to be much less likely to seek medical care. That's a big barrier to living a healthy life," adds Adolph Falcon, policy director of the National Coalition of Hispanic Health and Human Services Organization. "Hispanics tend to seek health care only when a medical condition has progressed to a serious threat to their health and they don't have a regular source of health care. A large number of them use emergency rooms like a clinic, where they're just going to get care on an emergency basis," Falcon says.

"They also don't have good medical records. They claim they were immunized, but it's difficult to find out whether they've really been immunized. In some cases, repeated work must be done and that's sometimes not good for the patient," says Martin Gonzalez, M.D., director of St. Elizabeth Hospital's family practice center. Dr. Gonzalez says a large percentage of Hispanics do not receive adequate pre- and postnatal care. In fact, in 1987, the mostly-Hispanic Humboldt Park neighborhood had an infant mortality rate of 20 deaths for every 1,000 live births, according to Fourcher. Statewide, the 1987 infant mortality rate was 11.6 per 1,000 births.

Diabetes hits Hispanic population

Diabetes is one of the major causes of illness and death among Hispanic Americans. According to the American Diabetes Association (ADA), Hispanic Americans are three times more likely to get diabetes than other Americans. Most of the available studies on diabetes among Hispanics have focused on Mexican-Americans. In the Northern Illinois area, 10-12 percent of Mexican-American adults, or 2 million individuals have diabetes. Of these cases, more than 95 percent have non-insulin dependent diabetes and nearly one-half million of them (484,000) reside in Chicago, according to the ADA.

A recent government study concluded that most Hispanics with diabetes are unaware they have the disease. When tested for diabetes, 61 percent of the men and 53 percent of the women in one Hispanic population were newly diagnosed, according to the study.

Explanations for the high incidence of diabetes among Hispanics include higher rates of obesity in Mexican-Americans, particularly women, lower family income and a

(continued on next page)

higher percentage of Native American genes. Native American Indians have an unusually high genetic disposition says an ADA source.

Educational efforts

Education is an important watchword among physicians who treat Hispanic patients. "One educator working in the South Lawndale area is developing a model program called the 'health promoters program'," says Teresa Nuno, special assistant to the Commissioner of the Chicago Board of Health. Nuno says she will network with a community based agency to train health promoters who in turn will train other lay people to educate Hispanics."

"Our educators also participate in health fairs and festivals sponsored by outside agencies as well as our own. We'll set up booths to distribute health literature or offer free measles immunizations or hypertension and diabetes screenings. We also work with aldermanic offices, churches and schools to develop additional programs to help Hispanics receive better health care," Nuno adds.

The Hispanic Health Alliance began its effort to educate Chicago's Hispanic communities in June. With a sizeable grant from the Chicago Community Trust, the Alliance instituted a 'self-care and wellnèss center program,' "to provide interested Hispanic groups with speakers knowledgeable in various health related fields to conduct weekly workshops and presentations on health education," says Maria Ayala, self-care and wellness center coordinator.

More physician involvement

Dr. Gonzalez says patients without access to health care should be referred to as many of these free health services as available. "Physicians need to help these people integrate into the American culture and encourage them to learn the language to gain better access to health care."

"A woman told me she has a newborn who needed to be seen by a pediatrician, but her husband was uninsured. This type of thing is happening in many communities and it's up to the physician to advise patients that there are a lot of free health services out there Hispanics should take advantage of," notes Carmen Vega, executive director of the Hispanic Health Alliance.

According to Father Michelini, not enough care stations offering food exist for Hispanics, based on the need. "We have a service center as part of our parish," he says. "When I came here in 1981, we were seeing about 30 Hispanic families a month. In eight years, we've easily tripled that number and not all of them belong to our church. They just live in the area and need care."

Physicians who treat Hispanic patients can obtain information on the topic in a booklet available from the National Coalition of Hispanic Health and Human Services Organization by calling (202) 371-2100.

Falcon says more physicians should also request that the American Medical Association include cross cultural education as a way for MDs to receive ongoing medical educational credits. "It is my hope that economic incentives will bring more physicians to get involved with Hispanic training. I think we all look forward to the day doctors' offices will have shingles out that say 'Se Habla Español'." ▲

ISMS targets Hispanic community in AIDS prevention outreach programs

The Illinois State Medical Society's (ISMS) AIDS and Adolescents Outreach Program, a statewide campaign which began last fall to educate teens and adults about AIDS, is expanding its efforts through its current outreach to the Hispanic community.

This month, Channel 44 (WSNS-TV) and a number of Spanish-speaking radio stations began extensively airing ISMS-produced public service announcements featuring teens and adults talking about AIDS prevention. The announcements, which will air for three months, include information on how individuals can receive free ISMS AIDS brochures in Spanish. The brochures, entitled "You can't be too careful: facts for teens (and their parents) About AIDS," are being inserted in Spanish-language newspapers, and have been made available free of charge in English or Spanish to physicians, schools and other organizations by calling (312)782-1654 or 1(800)782-ISMS and asking for the public relations department.

The ISMS AIDS and adolescents program also consists of a speakers bureau of physicians who have been trained to talk to teens about AIDS. To date, these physicians have spread their knowledge about AIDS to more than 100 junior high and high school classrooms as well as to PTA organizations across the state. All Illinois schools and PTAs have been offered the brochures as well as the opportunity for physician-speakers. Predominantly Hispanic junior and senior high schools are being specifically targeted this school year, to ensure their awareness of the free brochures and the availability of bilingual physician speakers.

The education factor

The ISMS effort recognizes the necessity of focusing on education in the battle against AIDS. Since



AIDS brochures in Spanish are available free of charge from ISMS.

the discovery of the disease in 1980, prevention has been the only safeguard against the fatal disease. But education targeted at certain populations like Hispanics has been difficult to enforce, largely attributed to language and cultural barriers.

"A lot of literature is being printed in Spanish, but because of illiteracy and low education among Hispanics, many of these folks won't be able to read. So you need a more personal approach such as physicians going to the schools and speaking to them or audio-visual materials that can be heard and seen," says Carmen Vega, executive director of the Chicago Hispanic Health Alliance (HHA).

Hispanic adults in the U.S. have a 2.7 times higher incidence of AIDS than non-Hispanic whites, according to the National Coalition of Hispanic Health and Human Services Organization (NCHHHSO). Hispanics accounted for 18 percent of the reported AIDS cases in October, according to the Chicago Department of Health (CDH). What's more alarming is that Hispanic children under 13 made up nearly half of the reported pediatric AIDS cases in 1988, "with the suspicions that there are plenty more HIV positive cases out there unaccounted for," warns Brian Chapman, program director for AIDS surveillance for the Chicago Department of Health.

While gay and bisexual men still account for the majority of AIDS cases among both the white and Hispanic population, "more cases of heterosexual IV drug users are making up an overwhelming number of AIDS cases among Hispanics," says Chapman. "A large number of HIV positive mothers develop AIDS later on and carry it over to their infants. We are seeing Hispanic women who are IV drug users themselves or who have become infected by their husbands. They have no idea about their husbands' drug habits or homosexual activities because of the lack of communication between Hispanic husbands and wives," Chapman adds.

"Many physicians give the responsibility of talking to the patient about AIDS prevention to the nurse," says Vega. "But whoever does it, they should talk to Hispanic women so they feel comfortable and so they can comprehend what the consequences of AIDS are. Gynecologists and other physicians should make sure the women understand the methods of transmission and that they are aware of many ways of protecting themselves," she says.

"We're still struggling with how to effectively reach the Hispanic communities in terms of education," says Adolph Falcon, NCHHHSO policy director. "We really haven't geared up to have the data, research and long term experience with reaching Hispanic communities with disease prevention and health promotion messages to know we're really launching an effective AIDS information campaign. Alcohol and tobacco industries have become very sophisticated in reaching communities. This is our first shot. We are much more likely to see a billboard advertising beer or cigarettes in these neighborhoods as opposed to health care."

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ISMS All Member Conference looks forward to the "challenges and choices" of the next decade

THE ILLINOIS STATE Medical Society (ISMS) All Member Conference, held November 17-18 at the Hyatt Regency in Oak Brook, presented a broad array of educational topics and input sessions for the 180 practicing physicians present from throughout the state.



Illinois Department of Public Aid director Susan Suter talks with ISMS president Eugene P. Johnson, M.D., at the 2nd ISMS Invitational Forum (see story opposite page).

"We in Congress need your input"

The Conference opened Friday evening, November 17, with a dinner speech by U.S. Rep. Lynn Martin (R-Rockford). Martin spoke to her audience live from Washington, D.C. via a telephone hookup, as Congress remained in active session.

"We in Congress desperately need your input on health care issues; otherwise, the medical system in this country will suffer," Martin told conference attendees, adding that "Every member of Congress should have a health care advisory committee." Referring to the catastrophic health care bill almost entirely repealed by Congress, Martin said, "I think long-term health care is going to be a big issue. But," she added, "big expanded programs are not going to be accepted, because the American people won't pay for them." Martin urged physicians to become as politically active as possible: the medical community is an integral part of the long-term health care solution, she said.



Glen T. Hammons, M.D., of the Physician Payment Review Commission.

Physicians' attitudes and behaviors

At the first session Saturday, November 18, psychiatrist Robert McDermott, M.D., medical Director of the Pennsylvania Medical Society (PMS) physicians' health program, told attendees that their training and experiences make them vulnerable when attacked by attorneys in malpractice suits. "Too many physicians," Dr. McDermott said, "particularly in the over-40 generation, take the attitude that 'The doctor is me!' So they are absolutely crushed when they are faced with a malpractice suit." This total identification with work, he said, also leaves doctors helpless in handling non-clinical situations. "We just don't know how to deal with the outside world—lawyers, administrators, business people, legislators." Dr. McDermott outlined a number of the personality traits he believes are common to doctors—control tendencies, time-consciousness, black/white thinking, narrow vision, and a belief in self-invincibility. Overcoming these difficult traits, he said, is the first step toward both a healthier mental outlook generally and a greater chance for victory in litigation.

Harry Schwartz, Ph.D., a noted economist, warned his audience that "American medicine is now in the process of suffering a major defeat" in the policy arena. A "schism of interests" among doctors, Dr. Schwartz said, is at the base of the medical community's political vulnerability at a time the country is grappling with the health care financing issue. The cost of health care, he said, continues to rise faster than inflation, because "When something is perceived as free, patients want more—more tests, more care."

There are only two possible solutions, Dr. Schwartz stated. "Either we abandon the pretext of free care—and abolish all first-dollar medical insurance"—one possible route being that "people would pay their own bills up to 10 percent of their own income, and the government pays the rest"—or "What is probably going to happen, is the status of doctors will gradually be reduced to that of hired hands, as in the Soviet Union. Undoubtedly, care will suffer."



State Representatives Barbara Flynn Currie and Thomas J. McCracken, Jr.

"Not necessarily better—just different"

After a spirited debate on the abortion and fetal tissue issues between State Reps. Barbara Flynn Currie (D-Chicago) and Thomas J. McCracken, Jr. (R-Westmont), and an overview of the 1990 elections from Thomas Hardy, Jr., political editor of the *Chicago Tribune,* and Dave Urbanek, capitol correspondent for the *Daily Herald,* physicians heard an eloquent presentation on the Canadian health care system from Hugh Scully, M.D., of the Canadian Medical Association.

Dr. Scully, a Toronto physician, told his audience that the Canadian system, despite a tremendous amount of mostly favorable recent coverage in the U.S. press, is "not necessarily better in every way" than the American system, "just different." (See Guest Editorial, page 5). Canada is struggling with many of the same issues as the U.S. is, Dr. Scully noted, but added that his country is spending 8.6 percent of its gross national product on health care—and that percentage is holding steady—while the U.S. is spending 11.4 percent, and it is rising annually. The U.S., he said, is spending too much.

Breakout sessions examine issues in detail

Three afternoon breakout sessions allowed for in-depth discussion of specialized subjects. All three were repeated a second time, so attendees could participate in two of them.

"How to Cope With the Peer Review Organization" provided physicians with insight on how Medicare's Illinois watchdog reviews cases for quality care and appropriate utilization. PRO representatives presented several case studies, and asked the audience to judge whether the medical conditions described warranted PRO concern. The speakers also cited several "PRO myths" which they'd heard circulating throughout Illinois' medical community. The PRO is currently conducting a series of regional workshops to educate medical leaders about the workings of the organization.

In "Medicare Funding: The New Push for Volume Control," Glenn T. Hammons, M.D., deputy director of the Physician Payment Review Commission (PPRC) outlined current PPRC recommendations to Congress, including a Medicare fee system to replace current "customary, prevailing and reasonable" payment guidelines, limitations on benefactors' liability, and expenditure targets for physicians. "Why are we moving from price control to volume control?" Dr. Hammons asked. "Price control alone didn't work, because Congress saw costs continue to escalate."

Finally, the session entitled "Defend/Settle Decisionmaking" engendered very lively debate among physicians. Using two Illinois State Medical Inter-Insurance Exchange case histories, a panel of experts led by Phillip D. Boren, M.D., ISMS trustee, examined two actual malpractice cases medically and legally, and asked attendees to decide whether to defend or settle the second, a case still in discovery. Attendees in both sessions voted overwhelmingly to defend. ▲





Photos by Wm. Daniels/The Photo Partners.

Left: risk management experts M. LeRoy Sprang, M.D., Lisa Kluzik and Paul Price discuss defend/settle decision making; Right: Robert McDermott, M.D., of the Pennsylvania Medical Society discusses physicians' stresses.

Board Briefs

The Illinois State Medical Society (ISMS) Board of Trustees met Friday, November 17, 1989 in Oak Brook. Following are highlights of the Board's actions:

OB care initiative

ISMS approved the following recommendations regarding the quality of obstetrical care for public aid patients:

- Physicians who treat public aid patients must have delivery privileges at a hospital that provides obstetrical care services or a written agreement for referral of the patient for delivery service with a physician who has such privileges.
- American College of Obstetrics and Gynecology standards on risk assessment should be used as guidelines to define services provided in a prenatal office visit.
- Public aid recipients should be assisted in obtaining needed social, educational and nutritional support services by Illinois Department of Public Aid (IDPA) support personnel, keeping the patient's physician informed of the services provided.

Board nominations

ISMS ratified the nominations of Earl Fredrick, Jr., M.D., Robert M. Vanecko, M.D. and Hugo R. Velarde, M.D., all of Chicago, for the IDPA state medical advisory committee. Michael DeStefano, M.D., of Riverside was nominated to assist the Illinois Department of Public Health (IDPH) in defining clinical indicators in evaluating quality of care issues. John Holland, M.D., of Springfield was supported as Chairman of the Medical Licensure Board.

Contracting handbook

A handbook designed to help physicians evaluate HMO, PPO and IPA contracts, and to assist IPAs in evaluating their payor contracts, will be produced and used for contracting seminars to be offered in 1990 to ISMS members.

Illinois Hospital Medical Staff Section

The ISMS Hospital Medical Staff Section (ISMS-HMSS) will hold its annual meeting February 10, 1990, at the ISMS Conference Center. An educational session will be held in the morning, and a business session in the afternoon. ISMS-HMSS representatives are elected by their hospital medical staffs to be a voting member of the ISMS-HMSS. ▲

Ethnic, specialty societies air issues at Invitational Forum

MEDICAL DISCIPLINE, public health initiatives and Medicaid headlined the agenda of the Illinois State Medical Society's second Invitational Forum, held November 17 in Oak Brook. Illinois ethnic and specialty society representatives gathered with ISMS leaders to hear reports from state government officials.

Robert Thompson, the Illinois Department of Professional Regulation's (IDPR) acting director, told the forum that during the last two years IDPR officials "have made a concerted effort to speed licensure and discipline. The department is currently preparing for the next medical licensure renewal period, which will begin in 1990. "It is the physician's responsibility," Thompson stressed, "to keep [his or her mailing] address current for renewal purposes." During the last renewal cycle, many MDs failed to notify IDPR of address changes, and were later disciplined for not renewing their licenses.

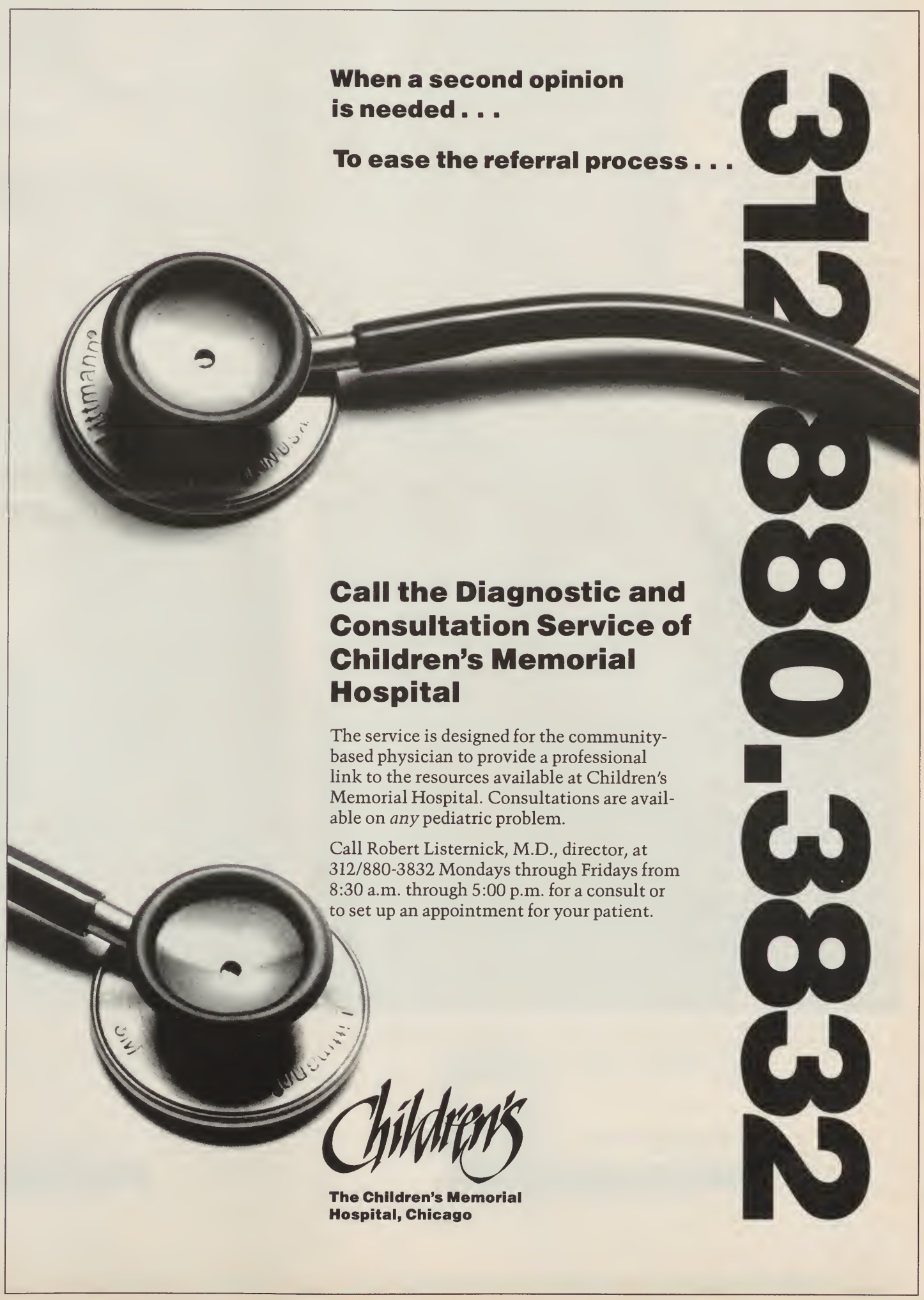
Illinois Department of Public Health (IDPH) director Bernard Turnock, M.D., highlighted initiatives on abortion, laboratory regulation, the state trauma and perinatal networks and maternal, child and rural health.

Dr. Turnock predicted settlement of the Ragsdale case (see story page 1), saying "the challenge for surgicenters is whether there will be minimum safeguards for abortions."

Turnock reminded MDs that the deadline for applications under the state's new Clinical Laboratories Act is approaching (see story page 2). "Our emphasis is to provide greater oversight of doctors' labs, while working to implement that process in the least onerous way," he emphasized.

Illinois Department of Public Aid (IDPA) Director Susan Suter outlined new Medicaid initiatives now under development. Suter envisions "Medicaid partnerships, contracts in communities with physicians and other health care facilities to provide ongoing health services and a choice of providers."

"Providers have the right to fair reimbursement," Suter stressed. She detailed recent progress made in boosting reimbursement to MDs and hospitals treating Medicaid patients. But she added that "We need to look at cost containment. The top two emergency room services for Medicaid patients were for colds and ear infections. We need to look at primary care services in the communities." ▲



Chicago launches strategic AIDS plan

by Kevin O'Brien

Following through on a promise made last spring, Chicago Mayor Richard M. Daley released the city's long-awaited AIDS strategic plan November 1. Release of the 400-page plan came three years after the city began developing it, and eight years after the city's first AIDS case was diagnosed.

"The plan reflects the best of all of our communities," said Daley, "including the academics, medical professionals, Hispanics, African-Americans, gays and lesbians. We can be proud of this powerful statement of unity."

Daley and Acting Health Commissioner Richard Krieg, Ph.D., also unveiled a print and electronic advertising campaign to increase awareness of the epidemic. Reaction to the strategic plan has been positive in general, though reviews of the ad campaign have been mixed.

Plan gets kudos

"I think it's great," said Judith Johns, executive director of the Howard Brown Memorial Clinic, of the strategic plan. Howard Brown, located on the city's north side, serves a large number of AIDS patients. "Finally," said Johns, "it shows a lot of commitment on the part of the city. One good part of the process was that it allowed people to put aside their specialty areas, and look at what was good for the city as a whole."

Johns was one of more than 140 members of the AIDS Advisory Council charged with developing an AIDS strategic plan by mid-October. Appointed by Daley and Dr. Krieg in May, the Council was given the task of helping to revitalize the city's foundering AIDS program. Dr. Krieg's predecessor, Lonnie C. Edwards, M.D., had been criticized severely for delays in the planning process, and for an AIDS activity office critics said was in disarray. Dr. Edwards had been appointed by the late Mayor Harold Washington, and continued to serve under former Acting Mayor Eugene Sawyer.

Chaired by John P. Phair, M.D., director of Northwestern University's comprehensive AIDS center, the AIDS Advisory Council was comprised of community leaders and health and social service providers involved in the epidemic in Chicago. The council worked through the summer to fashion the plan, which was then reviewed by a 25-member review panel before being submitted to the mayor.

The plan calls for implementation of more than 200 recommendations to combat Chicago's AIDS epidemic, including 14 action areas to be initiated by the city over the next six months. Some of these include cleaning up a grant-making process for community agencies that have experienced past difficulty; improving surveillance of the epidemic; improving treatment of drug abusers with AIDS (who will make up the next wave of patients); expanding counseling and treatment services; and improving coordination among city agencies dealing with AIDS.

Physicians will see some tangible benefits from the strategic plan, said newly-elected Illinois State Medical Society (ISMS) trustee Warren Staley, M.D. "The positives are that a great deal of information has been collected on the resources available to the physicians," said Dr. Staley, who, as medical director for the Chicago Department of Health, was also a member of the advisory council. "It has been broken down to modalities such as ambulatory care, inpatient care, emergency transportation and so forth."

Ad campaign shortcomings?

A major component in the city's expanded education program is an advertising campaign set to run on Chicago cable and commercial television stations and in the print media. Developed by DDB Needham Advertising at a reported cost of $750,000, the campaign's cost to the city will be only $75,000.

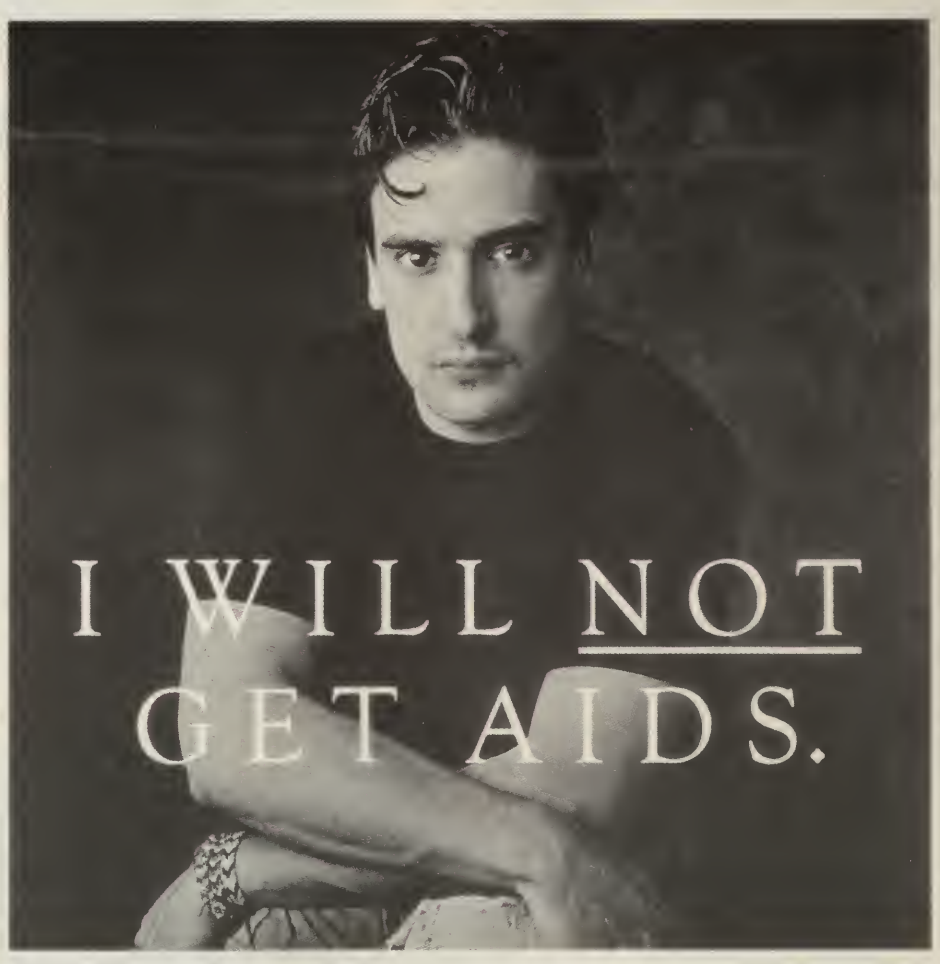
One AIDS activist group, ACT UP (AIDS Coalition To Unleash Power), charged the campaign provides some misleading or inaccurate information and characterized it as an inadequate response to the crisis. The group complained specifically that the television commercials do not mention the use of condoms. Responding to that criticism, Chicago Department of Health Director of Public Information Shirley Haas said, "I think that is an unfair comment. Very few television stations will accept advertising that carries the word 'condom.' If we put that word in the ads," she said, "they wouldn't be aired."

And, though Judith Johns expressed satisfaction with the strategic plan, she called the statement that no one need get AIDS anymore, which is an element in the ad campaign, misleading. Johns pointed out that no one need become HIV-positive anymore, but that a large number of individuals currently infected with the virus will manifest full-blown AIDS in the future.

Johns also contended that since the campaign is dealing with life and death issues, it must get tougher. "Now is not the time to be polite," she said. "Maybe people should be scared a little." ▲

Below, left and right: Two examples from the series of posters for Chicago's AIDS ad campaign. Targeted posters have been developed to attract the attention of specific groups, including black, white and Hispanic heterosexual men and women and gay men.





Authorities look into physician billing practices

by Eileen Norris

INSURERS AND STATE and federal authorities are taking closer looks at physician-submitted medical claims to monitor billing practices which they say cross over the line to abuse and—in rare cases—even fraud.

Investigators for the state and for insurance companies say that only about two percent of the state's doctors are billing for medical procedures they have never performed, or are committing other flagrantly deceptive acts. But there is an apparent gray area of billing that can give the physician the opportunity to maximize his or her income—and also lead to legal trouble with the regional Office of the Inspector General and the Illinois Attorney General's office.

That practice, known as "unbundling," or multiple service pricing, involves breaking down one major code into several different reimbursement codes in order to get more money than is allowed under the typical code schedule. It is a questionable method of billing that is getting "red-flagged" by insurers such as Blue Cross/Blue Shield (BC/BS) of Illinois.

"It's billing $9,000 for a $4,100 lobectomy by using multiple codes," explains Bradford Buxton, vice-president of health care services for BC/BS of Illinois.

"For example, instead of billing us for a $4,100 lobectomy, we'll also be billed for a $3,900 incision, and another $800 for inserting a tube when the first procedure should have covered the entire bill," says Mr. Buxton. "To us, that's abuse."

Billing concerns growing

The "Blues" have about 2.3 million subscribers in Illinois, and Mr. Buxton estimates that about two-thirds of the state's doctors bill BC/BS for their Medicare patients.

While "unbundling" is not new, insurers believe they're seeing more of it because the Current Procedural Terminology (CPT) codes published by the American Medical Association have been expanded.

Still, says Jean Mosebach, a manager of Ernst & Young's health care consulting group, "We never advise unbundling to clients.

"But," stresses Mosebach, "it is crucial for physicians to know what the various carriers will and will not accept. The doctor and his office staff should be proficient in both the most current CPT codes and International Classification of Diseases (ICD) codes." Beginning October 1, 1989, physicians were required to submit both codes with claims. The ICD code is specific to the diagnosis while the CPT code defines the medical treatment given.

Insurers like BC/BS are also keying in on "upcoding," or coding a procedure as more severe than it actually was to gain the additional revenue; and on a practice they call "churning," or seeing patients more frequently than needed.

Until now, when the insurer felt it had targeted an abuser of the claims reimbursement system, its claims auditor or investigator simply called the physician and informed him/her that they were overbilling.

"Some physicians don't concern themselves with billing and are unwitting, but they need to know what we consider to be an abuse of the system," says Buxton.

BC/BS says it is now strongly considering readjusting its claims system so that its computers will automatically rebundle an unbundled claim and just pay for the major code.

"What we don't want to see," stresses Buxton, "is the physician balance billing the subscriber patient for the amount we won't pay. The patient should not be put in the middle of this. This is an insurer and provider issue."

He adds that there are times when unbundling is appropriate, as when surgery requires a radical departure from normal medical procedure.

"But in those cases, the physician should put a modifier on the claim so we understand why charges are unbundled," he says. Mr. Buxton stresses that BC/BS does accept multiple codes in such atypical cases.

When a physician, subscriber or pharmacy knowingly falsifies a claim, The BC/BS fraud control center steps in and one of its five fraud investigators gets to work on tracking down the offender. The unit has been in business only since 1987, but it has saved and recovered $2.8 million in that short period of time. The fraud unit has about 700 cases pending and estimates that it will realize a $1.5 million savings in 1989.

Many of the claims are at the state and federal level, with most falling under the mail fraud statute. "There is a federal law against using the mail to perpetuate a fraud and when a provider or subscriber submits a fraudulent claim through the mail, and we catch him and convict him, each count holds a $1,000 fine and carries a sentence of up to five years in prison," says Ken Jansson, vice-president of audit and performance review for BC/BS of Illinois.

"We are most interested in provider fraud, frankly, because that's where we see the potential for the greatest loss of dollars," says Jansson. "Fraud directly affects a doctor's premium and costs and it's an opportunity for us to identify someone who's using the system for gain and to put that person out of business. It detracts from the profession."

Office of the Inspector General

Not just insurers are going after illegal billing procedures. The regional Office of the Inspector General (OIG) has about 100 ongoing criminal and civil investigations on its books, says Thomas Tantillo, assistant regional director for health care investigations for the six great lakes states. He has a dozen investigators who concentrate exclusively on Illinois.

Tantillo estimates about 60 percent of his caseload comes from BC/BS (the Medicare agent in Illinois) and from Medicaid, the health insurance for the indigent which is funded 50/50 between the state and federal governments.

There's also the Illinois Department of Public Aid, which, through the efforts of its bureau of medical quality assurance (BMQA) may identify prospective fraudulent practices by Medicaid providers. Any allegations or suspicions are referred to the Illinois Department of State Police's Medicaid fraud control unit, which was established under state law.

Instances of potential fraud are detected primarily through two means: referrals or complaints (the IDSP has an "800" number telephone hotline) and IDPA review activities. The unit may choose to pursue civil or criminal action, using an assistant attorney general to prosecute cases. The BMQA currently has 292 audits in process and in fiscal year 1989 says it collected $4.7 million.

Patients, competing doctors, and current and former employees also play a part in blowing the whistle on a physician they suspect of fraud. OIG initiates about 40 percent of its investigations after receiving information from those sources, says Tantillo. Many complaints of wrongdoing come in anonymously through the OIG fraud alert hotline.

For OIG to pursue a case against a doctor, it must be a criminal offense, and one that can be proven. OIG won't take a case unless it believes it can get a successful prosecution against the accused, he says.

"Greed is addictive," he adds. "It might start out small enough but abuse can quickly cross the line. I believe doctors know what's ethical and appropriate. And if there's any gray area or doubt in their mind, they should seek competent legal counsel." ▲

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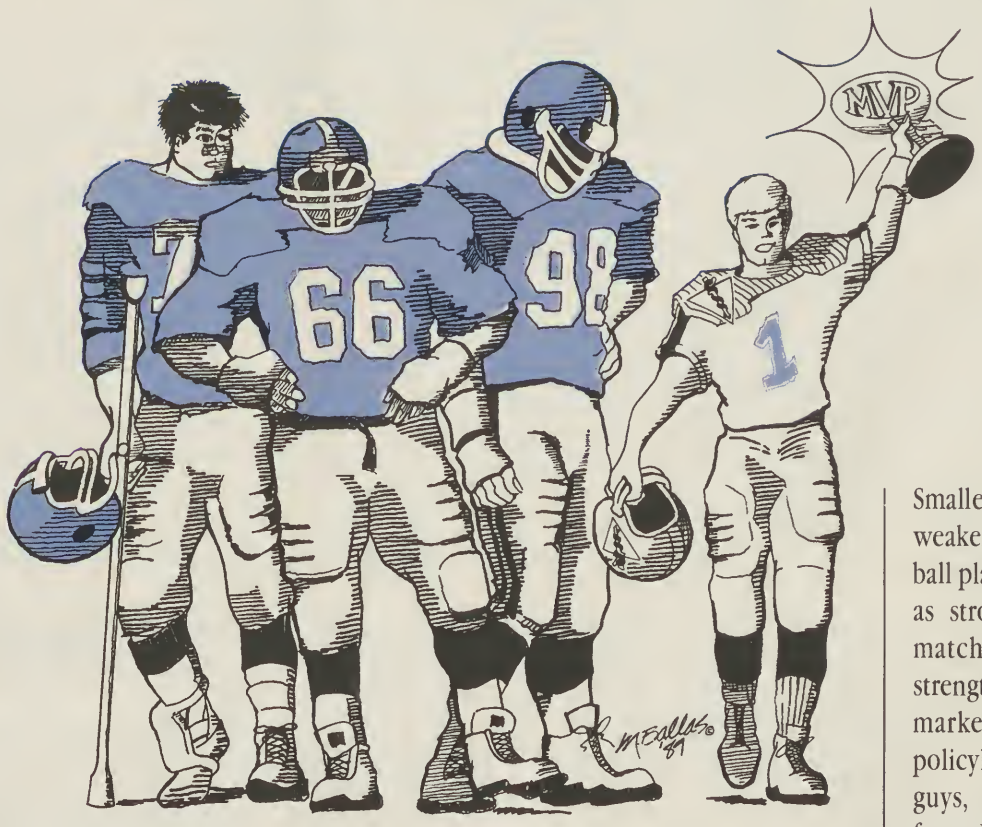
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Abortion *(continued from page 1)*

The agreement will permit IDPH to create a new category of special surgical centers which may perform abortions exclusively. Procedures in these centers must be performed with no general anesthesia or incision up through the 18th week of pregnancy only. In addition, the settlement retains physicians' right to perform abortions in their offices, and recovers IDPH's ability to enforce abortion regulations in ambulatory surgical treatment centers (ASTC).

Dr. Turnock will be drafting new regulations to govern the operations of the new category. These regulations will modify some physical plant provisions of the existing ASTC regulations, specifically, corridor widths, room size, and heating and ventilation requirements.

IDPH was enjoined from enforcing the regulations affecting abortions in ASTCs four years ago when U.S. District Court Judge John A. Nordberg ruled in favor of Dr. Ragsdale's suit challenging them. Dr. Ragsdale contended that compliance would be prohibitively expensive for most abortion clinics, denying poor women their constitutional right to an abortion.

The U.S. Court of Appeals sustained the ruling on March 10, 1988, and oral arguments in the Supreme Court were scheduled for Dec. 5. On the day they announced the settlement, the parties filed a joint motion asking the Court to defer any further action pending a "fairness hearing" on the settlement in district court. If Judge Nordberg disapproves the settlement, however, the case can return to the Supreme Court.

Four major outcomes

Commenting on his goal to protect the health and safety of Illinois women having abortions, Dr. Turnock said "we have accomplished all that we would have hoped to accomplish by taking this case to the Supreme Court. In fact, we may have accomplished all that the plaintiffs wished to accomplish as well."

Dr. Turnock said there are four major outcomes of the settlement:

- Previous decisions allowing physicians to perform abortions in their offices are affirmed;
- IDPH's authority to license and regulate outpatient surgery centers that perform abortions and other procedures is recovered;
- IDPH will now be able to enforce the abortion regulations in ASTCs; and,
- IDPH can create a subset of regulations directed to outpatient surgery centers that perform abortions exclusively.

"Illinois women are the real victors in this resolution of the Ragsdale/Turnock litigation," said ACLU attorney Colleen Connell. Connell said that women will now have the option of seeking an abortion from their private physician and, if medically appropriate, choose to have the abortion performed in the physician's office. The women may also choose an abortion clinic that will now be regulated, or use an ASTC or even a full-service hospital.

While many of the ASTC physical plant requirements will be relaxed in the new regulations governing abortion clinics, many medical care provisions including the requirement that physicians performing abortions have hospital privileges will be retained, Dr. Turnock said.

He said that because IDPH has been enjoined from enforcing abortion regulations, there are no reliable statistics on the percentage of abortions performed after 18 weeks in Illinois, but nationally, the rate is certainly less than 5 percent and probably less than 2 percent.

Reaction divided

"The Illinois State Medical Society (ISMS) has long supported regulation of ASTCs," said ISMS President Eugene P. Johnson, M.D. "The agreement reached in the Ragsdale case is consistent with our support of reasonable, medically necessary, but not overly burdensome regulation of clinics where surgical procedures are performed." Dr. Johnson said ISMS will monitor the development of the new regulations and provide input.

But, Mark Mayo, executive director of the Illinois Freestanding Surgery Center Association (IFSCA), which represents 20 of the 47 currently licensed ASTCs, said his organization will be meeting with state officials December 6 to assess the implications of the agreement. "It's not clear whether the Attorney General has created a new class of surgery center, whether IDPH has approved rules and regulations for different types of surgery centers, or whether the state is promulgating rules and regulations without the approval of the Ambulatory Surgical Treatment Center Licensing Board as required by law," Mayo said.

Ann-Louise Lohr, staff counsel for Americans United for Life, expressed disappointment in the settlement, contending that Hartigan has engaged in a "backroom deal that will compromise the ability of all states to protect the health and safety of women." In a prepared statement, she added, "Anything short of a full hearing before the U.S. Supreme Court is a slap in the face of the Illinois citizens who have entrusted their General Assembly to enact legislation that protects women."

A spokesperson for Dr. Ragsdale told *Illinois Medicine* that he will not comment on the settlement until after Judge Nordberg rules on the consent decree. ▲

Clinical Lab Act
(continued from page 2)

and any physician who performs one or more of these tests need only register his/her office lab with IDPH. There is no fee involved and there are no other requirements to meet. There is simply a form to be filled out listing the tests that are done," Mitchell points out.

Even if physicians are performing other tests in their office labs, they need not apply for a class I or class II permit if they are conducting the tests on their own. "If no one else is doing the tests, if it is only the physician who is running all his own tests, regardless of the type of test, all the physician needs to do is register with IDPH," Mitchell notes.

Also helpful are the criteria listed in the Clinical Laboratory Act's rules and regulations section distinguishing class I permit tests from class II tests (see box on page 2). "What we are asking people to do is to look at these criteria and determine that, 'Yes, the individual tests that I do are simple ones,' and have them fill out a permit level I application," says Mitchell. "If the tests are clearly not simple, then we are asking them to file for permit II."

The criteria are intended to "distinguish between those tests that require trained personnel to operate, compared with those that can be done by anyone," says Mitchell. They include the involvement of machinery or instrumentation in performing a test ("Can you put the sample in one end of a machine and pull the result out of the other?"); the amount of technical judgment involved ("Are the values directly interpretable or must there be some computation?"); and the sensitivity of the equipment to calibration ("Do you have to reset the machine frequently?").

Making the differentiation between simple and complex tests "should be easier than most people are making it," says Mitchell. But some physicians disagreed.

"It is true that it will be easy for physicians to figure out whether they fit into class I or class II once there is a clear definition of a simple test," says Richard Sassetti, M.D., chairman of ISMS' committee on blood banking and laboratory services. But, he stresses, "Much effort has been expended in trying to define a 'simple' test, and [regulators] are still struggling with this."

Using the simple test criteria that are listed in the Clinical Laboratory Act is "an oversimplification," Dr. Sassetti adds. "There are a lot of subtleties in those criteria that physicians may miss."

Mitchell points out that "there won't be any punitive action taken [against physicians] for guessing wrong. If we later decide a test is more complex than the physician thought it was, there will only be a higher fee involved."

Physicians should nonetheless be aware that class I and class II labs do have specific proficiency testing and quality control requirements.

For physicians with labs in classes I and II, "You have to get proficiency testing for the tests you're doing by either the College of American Pathologists or the American Association of Bioanalysts," says Mitchell. Proficiency testing involves analysis of an unknown specimen which is provided by the proficiency testing service in the same manner as any other patient sample would be tested.

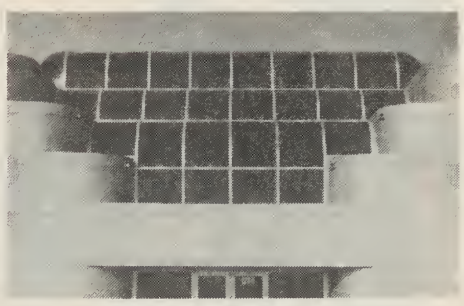
The laboratory sends the testing agency the results of its tests, and the agency determines how close the lab has come to the assayed value. The agency must also send these results to IDPH.

Quality control "is a less specific requirement; so we probably are not going to enforce it as directly," Mitchell acknowledges. However, he suggests that physicians probably will need to have documentation of the quality control procedures or the methods of using control samples that they follow and their instrumentation maintenance programs.

While the expertise of the individuals who perform the tests differs for class I and class II permit labs (a lab assistant is required for class I; a technician is required for class II), "Our rules don't require any of these individuals to be certified by outside agencies," says Mitchell. "All they have to do is meet the requirements that are set out in the rules." ▲

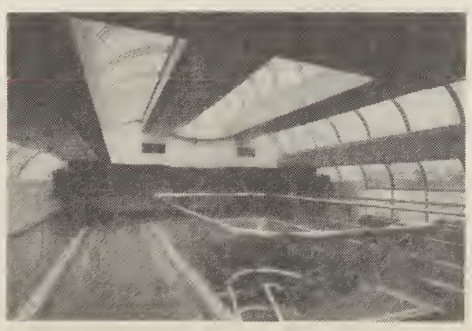
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Midwives

(continued from page 1)

General Assembly declined to issue any new licenses. The 1987 revision of the Act deleted midwifery licensure entirely.

In 1986, Maggie Jihan, formerly of Jackson County, now living in California, was convicted for practicing midwifery without a license after aiding in a fatal delivery in Makanda. The Illinois State Supreme Court ruled earlier this year that Jihan's conviction was unconstitutional because of the vagueness of the state's midwifery law.

The Act's deletion of midwife licensing was challenged again when Betty Peckmann, a midwife from Normal and her assistant Kim Perry, an apprentice midwife from Decatur, were charged with practicing medicine without a license after a fatal home birth in Taylorville a year ago. The criminal prosecutions against Peckmann and Perry were dismissed under the condition that the women agree to file a federal lawsuit "to clarify the law as it now stands so there would no longer be this gray area where no one knows whether the Act outlaws the practice of midwifery or not," said Perry who is filing the suit "on behalf of myself and the class of those who wish to study midwifery."

"Midwives" defined

"In Illinois, certified nurse midwife is a registered nurse already licensed in the state of Illinois who has additional educational preparation, leaning towards a masters degree in maternal child nursing with a specialty in nurse midwifery," explained Joan Bundley, Illinois Nurses Association (INA) deputy executive administrator. "After taking the certifying exam," Bundley said, the applicant "becomes a certified nurse midwife (CNM), which is added to the registered nurse (RN) designation. A lay midwife is what I call a birth attendant." INA has supported certifying licensed nurses as midwives.

A traditional midwife, commonly referred to as a lay midwife, is "trained outside of the nursing profession," said Perry. "Most traditional midwives have received apprenticeship training in combination with academic study. Traditional midwives also may receive certification from the Illinois Alliance Certification Program, a state organization," not to be confused with certification earned by certified nurse midwives.

While the Illinois section of the American College of Obstetrics and Gynecology (ACOG) "supports the practice of certified nurse midwives," said ACOG president Merrill Huffman, M.D., "we do not support lay midwifery. Those who practice midwifery should be licensed. The Medical Practice Act is designed to regulate the practice of the healing arts and therefore lay midwifery should be addressed," he said.

Zukosky said he will argue in court that "Because obstetricians and gynecologists are backing out of the business, and hospitals are closing throughout the state, citizens in Illinois are being deprived of having natural home births, and of any care at all. Traditional [lay] midwives can really help fill this void and help increase birthweights and reduce infant mortality."

"ISMS has opposed lay midwifery as medical activity not supervised by a physician," said Eugene P. Johnson, ISMS president. ISMS policy on nonmedical personnel states, "It is the position of Illinois State Medical Society that sick people should receive appropriate care under the direction and supervision of a physician licensed to practice medicine in all its branches. Professional services provided by ancillary health professionals plays a vital role in care and are encouraged but should not be provided without the direction of a physician."

Neither IDPR nor IDPH spokespersons had any comment on the lawsuit, while the Illinois Attorney General's office had not responded at the time *Illinois Medicine* went to press. The named defendants in the lawsuit have 60 days to file a response. ▲



Summit

(continued from page 1)

the remainder in the city. Originally, only six hearings were to be held, four in the city and two in the suburbs, but more were added to the city schedule at the suggestion of several summit members.

The 39 policy steering committee members were asked to serve as hearing panel members for each of the public hearings. It is hoped that between five and six persons will comprise each hearing panel. The policy steering committee is charged with developing a set of principles that will be used by the 10-member system design and management committee in drafting specific recommendations. The recommendations are due April 15 so that necessary legislation can be drafted for introduction in the General Assembly's spring session.

Approved schedule

The approved city hearings dates and sites are: Thursday, December 14 at Truman College, 1145 W. Wilson; Saturday, December 16 at the Austin Town Hall, 5610 W. Lake St.; Wednesday, January 3 at Malcolm X College, 1900 W. Van Buren; Thursday, January 4 at the Urban League headquarters, 4510 S. Michigan; and Monday, January 8 at Association House, 2560 W. Hirsh.

A hearing in Arlington Heights is scheduled for Thursday, January 11 at the Elk Grove Village Township Hall, 2400 S. Arlington Heights Road.

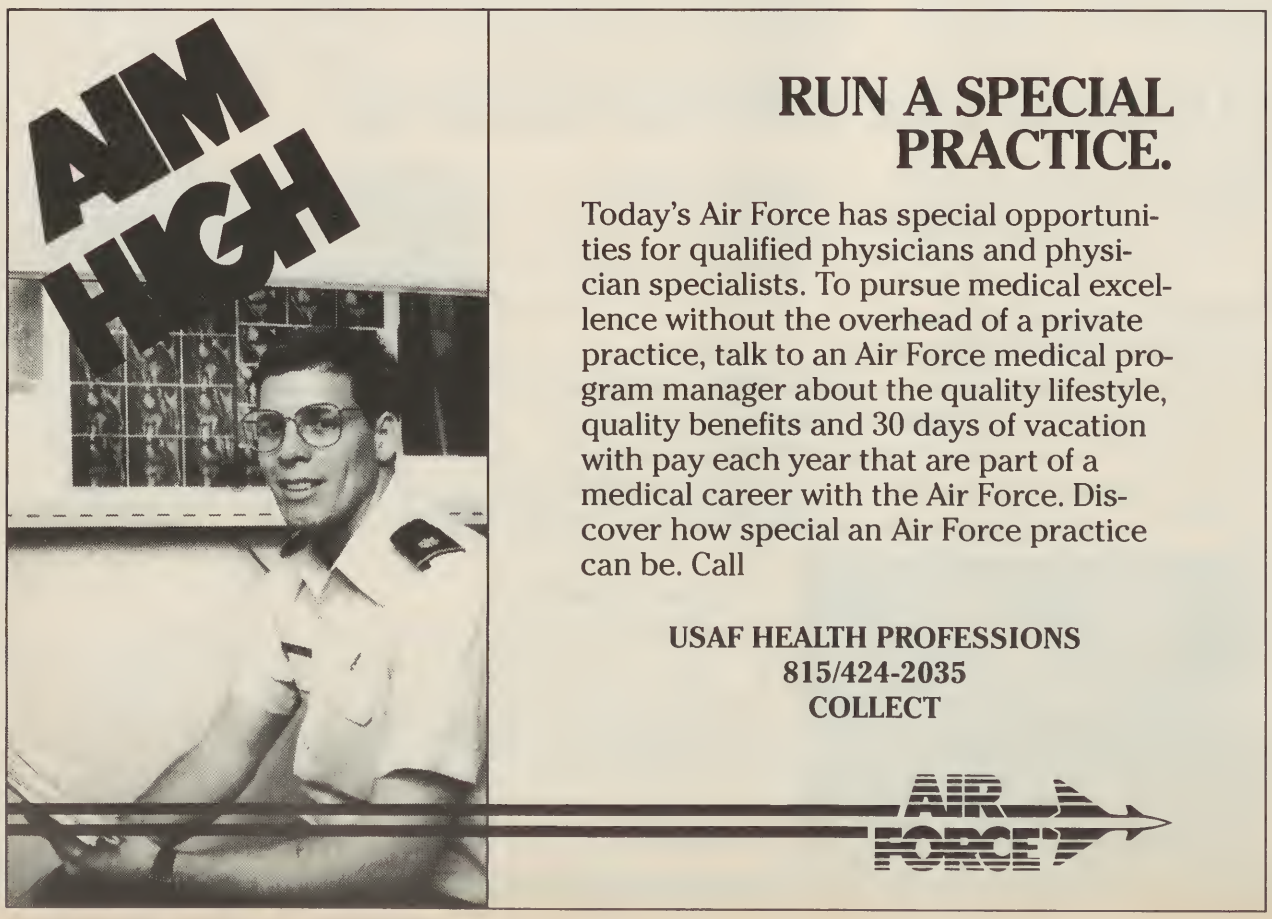
Weekday hearings are scheduled from 6:30 p.m. to 10:00 p.m.; Saturday hearings will be from 1:00 p.m. to 4:30 p.m. IDPH officials said that summit members have already recommended many potential individual and organizational witnesses. These people are now being contacted and will be scheduled if they wish to testify. However, officials said they plan to reserve about half of the witness slots for those who show up at the hearings. These will be scheduled on a first-come, first-serve basis and will be asked to testify at only one hearing.

Questions for witnesses

The committee also approved a list of four questions that witnesses at the public hearings will be asked to address. First, the committee is interested in hearing specific examples of problems people encounter in getting quality health care in their respective communities. Second, they want to know about what kinds of problems are encountered in getting different kinds of health care services in the community. Witnesses will be asked whether there are connections between the various kinds of needed services.

Third, the committee wants to know witnesses' recommendations for specific actions to address the problems of access to services. Finally, witnesses will be asked whether certain health care services, such as infant and maternal care, AIDS services, and trauma care, should be emphasized in the summit's final recommendations.

Witnesses will have five minutes each for their oral testimony following which panel members may ask questions. Organizations will be limited to one individual spokesperson. IDPH will also accept written testimony, which should be sent to the Policy Steering Committee, Attn: Jackie Ellinger, State of Illinois Building, 100 W. Randolph Street, Chicago, Illinois 60601. People having questions regarding either oral or written testimony may call (312)337-7400. ▲



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Psychiatric malpractice: claims are rising . . . 6

Illinois Medicine

December 22, 1989 ILLINOIS STATE MEDICAL SOCIETY



The Springfield County Medical Society Auxiliary raffled off this "lovingly made" gingerbread house December 13 to raise money for the Illinois State Medical Society Benevolence Fund. January 1990 marks the fund's 50th anniversary of providing modest financial assistance to physicians and their families in need because of death or illness.

Ron Ackerman

Part three in a series

Federal report looks at rural emergency services

by Kevin O'Brien

ACCESS TO emergency medical services (EMS) for the one-quarter of Americans living in rural areas is unusually difficult, but problems could be alleviated through more federal resources and better state planning, concludes a federal report released November 21.

The report, titled *Rural Emergency Medical Services,* was issued by the U.S. Congress' Office of Technology Assessment (OTA) at the request of members of the Senate's rural health caucus, including Illinois Senator Paul Simon (D).

The report says the average American requires ambulance service at least twice in his lifetime, but that the wide dispersal of the rural population inhibits quick delivery of emergency services. Moreover, because small rural communities may receive less than one emergency call per day, rural ambulance services face difficulty staying in business.

The result is a series of nationwide problems, according to the report, including EMS personnel shortages; inadequate advanced training op-

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Blue Cross announces statewide crackdown on "unbundling" abuse

ILLINOIS BLUE CROSS/Blue Shield (BC/BS) officials announced December 5 a statewide crackdown on what they termed a "growing trend in abusive billing practices for physician services."

"Some physicians—chiefly surgical subspecialists—are performing procedures and using separate billing codes for each part of the entire operation as though each part were an independent operation," said Arnold L. Widen, M.D., Illinois BC/BS medical director. The process, known as "unbundling" because the individual computing the billing takes apart a combined current procedural terminology (CPT) code and bills separately for each element, is on the increase, Dr. Widen said. The insurer is determined to end all unjustifiable unbundling through installation of a computer tracking system.



Arnold L. Widen, M.D., Illinois BC/BS medical director. Wm. Daniels/The Photo Partners

Designed in-house at BC/BS, the computer "will automatically repackage [unbundled] bills to charge the usual and customary fee," Dr. Widen said. He added Blue Cross will be "notifying all physicians in Illinois of the abuse and urging them not to unbundle claims; notifying [physicians'] billing services that they will be dropped from the Blue Cross list of approved billing services if they continue the practice; [and] as a last resort, if the physician refuses to cooperate, dropping the physician from the company's participating physician programs."

"A very small percentage of MDs"

"The great majority of physicians are not doing this kind of billing," said Dr. Widen, adding, "We have received considerable support from individual physicians in our efforts to clean up the unbundling problem." Unbundling accounts for perhaps five percent of surgical claims, Dr. Widen said. He estimated that Illinois BC/BS would lose "perhaps $25 to 30 million" in 1989 through the practice.

(continued on page 10)



Wm. Daniels/The Photo Partners

George T. Wilkins, M.D., ISMS delegation chairman.

Illinois resolution goes to AMA board for decision

AMA to continue investigation of financial irregularities

THE AMERICAN MEDICAL Association's (AMA) Board of Trustees will continue and broaden its investigation of inappropriate financial transactions and consider studying AMA's management, administrative, managerial and policy-making processes as a result of AMA House of Delegates action in early December.

At its interim policy meeting in Hawaii, the AMA House adopted a board report calling for the investigation, and referred for AMA board decision the Illinois State Medical Society's (ISMS) Resolution 130. The 435 member House of Delegates is AMA's chief policy-making arm.

ISMS Resolution 130 called for outside legal, financial and management consultants to investigate AMA's financial, administrative, management and policy-making structures and report to the House at its June, 1990 annual meeting.

"The comprehensive nature of our resolution stemmed from concerns about AMA's effectiveness, which far preceded the two financial incidents brought to light by the Chicago *Sun Times,*" said Harold L. Jensen, M.D., ISMS board chairman from Frankfort. "ISMS members are concerned about whether the AMA is effectively representing its members. We want the whole structure reviewed by out-

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Survey shows AIDS education helps youth, but gaps remain

by Kevin O'Brien

AIDS EDUCATION campaigns aimed at Illinois high school students seem to be paying off, but there is still a long way to go, a new Illinois Department of Public Health (IDPH) statewide survey reveals.

Both the general population and a separate sample of minority youth were polled in the third such survey commissioned by IDPH. Since the first poll in early 1987, 17 percent more people said they were taking precautions to avoid infection. Among minority youths, 14 percent reported changing their behavior in the last year alone.

Moreover, clear majorities of those polled support school-based education efforts beginning at the elementary school level. They also say the government should spend at least as much money to help AIDS patients as it does to help those with other serious health problems.

"This survey shows not only that aggressive education efforts work, but that there is broad public support for government programs to tell people about this deadly disease and how it can be avoided," said IDPH director Bernard J. Turnock, M.D.

Precautions taken by surveyed teens include condom use and more careful selection of partners. Reported condom use among minority youths has nearly doubled, from 14 percent in August 1988 to 24 percent now. "Last year, those aged 16 and 17 were among the least knowledgeable," said Richard Day Research, Inc., in a summary of its findings. "Today, they are among the most informed."

The survey was conducted by telephone between June 21 and July 3; results are based on a statewide random sample of 809 Illinois residents aged 16-65, and a separate random sample of 208 black and Hispanic residents aged 16-25. For purposes of analysis, Illinois was broken down into five regions: Chicago, Cook County, the collar counties, urban downstate and rural downstate.

Despite gains in AIDS awareness, however, the survey shows that significant misconceptions persist. Nonwhite and lower income respondents are still the least informed about the disease and its transmission. Forty-four percent of the young blacks and Hispanics did not know that an HIV-infected person remains so for life, while a third of the general population remains unaware of this fact.

Also, while nearly all (97 percent) respondents knew that AIDS is transmitted sexually or through the sharing of needles, a majority of both samples, especially minority youths, still believe that one is likely to get AIDS by kissing or through a blood transfusion.

"This survey shows progress made and progress yet to be made in the AIDS area," said Eugene P. Johnson, M.D., Illinois State Medical Society (ISMS) president. "We at ISMS remain concerned about developments in the battle against this threat to public health. Our own AIDS outreach programs," Dr. Johnson added, "are designed to address teens specifically, as we feel they are at special risk of infection, due to their high level of sexual activity and some teens' willingness to experiment with drugs." ISMS' AIDS program encompasses print and video materials targeted toward both English- and Spanish-speaking teens, as well as a speaker's bureau.

Education programs directed to both elementary and high school students receive substantial support, the survey shows. Among the general population, 56 percent say programs should start in the lower grades. The vast majority of respondents, 85 percent of the general population and 91 percent of the young minorities, say children with AIDS should be allowed to attend school with other children. These findings correspond with ISMS policy.

Physicians are still the primary source for AIDS information, but the percentage is declining as other sources, such as clinics, IDPH and local health departments, and AIDS hotlines gear up to provide specific information. Thirty-four percent of the general population say their primary source is physicians compared to 44 percent in 1988 and 50 percent in 1987. Twenty-eight percent of minority youths said their physician was their primary source, compared to 34 percent last year.

Still, physicians continue to rank as the most credible source for accurate AIDS information (91 percent generally and 90 percent among minority youth). Public health departments and the U.S. Surgeon General follow with rankings in the upper 80 percent range.

A majority of respondents also support a policy of non-discrimination toward people with AIDS to promote testing and counseling of potentially infected persons. Moreover, fewer people than in previous years believe homosexuals comprise the group most likely to be infected. That group has been replaced by intravenous drug users. ▲

Clinical lab act: a reminder

If you operate a physician office laboratory you must submit an application to the Illinois Department of Public Health (IDPH) by December 31, 1989 to be in compliance with the Illinois Clinical Laboratory Act. Applications and copies of regulations are available from IDPH's division of health care facilities, 535 West Jefferson, Room 450, Springfield, IL 62761.

Auxiliary sharing card gets boost from ISMS board



Card design by auxilian Ann Cunningham.

The annual Illinois State Medical Society Auxiliary (ISMSA) holiday sharing card is being co-sponsored this year by the Illinois State Medical Society (ISMS), a first, according to ISMSA officers.

The card, which represents the fund-raising efforts of auxilians on behalf of the American Medical Association Education and Research Foundation (AMA-ERF), has been produced by ISMSA for three years, says Nancy Hoffmann, Rockford, ISMSA president. All funds are channeled through ISMSA to the AMA-ERF for assistance to education and research in medical schools.

"The joint ISMS-ISMSA sponsorship," says Mrs. Hoffmann, "is a way for us to show symbolically that we are concerned about and involved in some of the same important issues."

Each participating county medical society sends out fliers soliciting contributions for its greeting card from county member families. Contributors' names are listed in the county card, which is sent to all member families in the county. Last year, says Mrs. Hoffmann, "about half" of the county medical societies participated in the ISMSA project, forwarding their contributions to ISMSA for transmittal to AMA-ERF. The ISMSA card appears in the December issue of the auxiliary's quarterly newsletter, *Pulse*.

The AMA-ERF, established in 1953, allows donors to contribute to the medical school excellence fund, which provides grants to medical schools for such projects as building improvements, faculty salaries, books, and student loans and grants; and the medical student assistance fund, which provides funds to medical schools for direct financial aid to students.

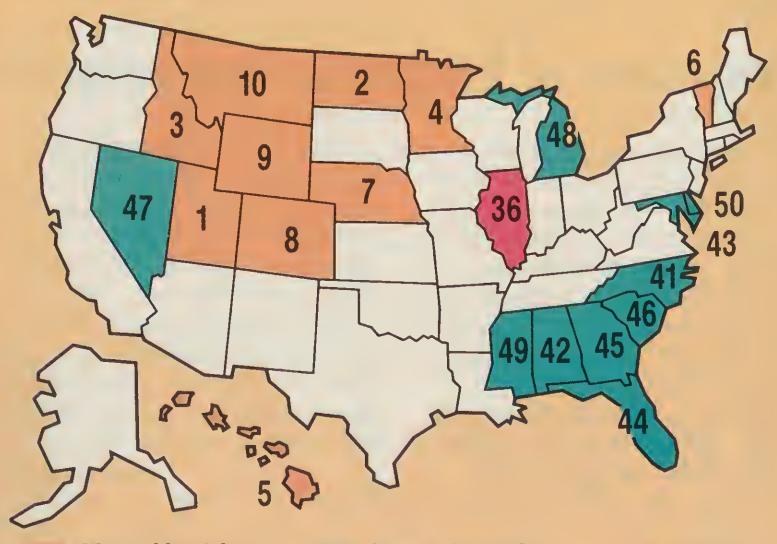
"This is a form of helping assure quality medical education and research in medical schools," says Karen A. Girardy, Illinois state chair for the AMA-ERF and past president of the Winnebago County Medical Society Auxiliary (WCMSA). "It's also a way for physicians to 'pay back' their medical school," she says. "A lot of people this year have specifically requested that their donations go to the assistance fund."

Through efforts like ISMSA's, medical students are receiving tangible benefits, says Sherry S. Betsill of Springfield, a member of the AMA-ERF national committee. "Illinois is very strong," she adds. "For the past three years, our state has been fourth-highest nationally in terms of its auxiliary contributions to AMA-ERF. It's also been fourth-highest in physician contributions to AMA-ERF." Mrs. Betsill is also last year's ISMSA president.

"Our hope," Mrs. Hoffmann concludes, "is that physicians and their families will use the holiday sharing card opportunity as their method for contributing to medical schools." ▲

Physician Facts

Ranking Healthiest State Populations: Ten Highest and Ten Lowest



Six factors were evaluated to produce each state's overall rank. States were rated for each factor and assigned an overall ranking based on the six factors.

Illinois ranked 37th in life expectancy; 37th in avoidance of disease; 31st in good health habits; 24th in access to medical care; 13th in productivity least affected by illness; and 36th in low rate of premature death.

Source of Data: Northwestern National Life Insurance Company, 1989

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State agencies, MDs lend perspectives on licensure, regulation of residents

MORE THAN 100 residency program directors and their staffs attended the second annual seminar for residency directors sponsored by the Illinois State Medical Society (ISMS) on November 29 in Chicago. Individuals from state regulatory and accreditation agencies and practicing physician volunteers serving the state gave attendees perspectives on licensure and regulation.

Reviewing last spring's temporary licensure process for incoming medical residents, Pat Eubanks, Illinois Department of Professional Regulation (IDPR) section manager for medical licensure said IDPR received the majority of its 1989 temporary license applications by late May or early June and 1,268 approved applications were returned to hospitals prior to the July 1 residency start date.

Only one foreign medical graduate's application for temporary licensure was denied based on state law requiring pre-1985 medical school graduates to have clinical skills evaluated before issuance of a license. No applicants seeking permanent licensure were denied based on the pre-1985 guidelines.

Eubanks said the instruction sheet and other parts of the temporary license application form have been made more specific to help alleviate missing information problems for the 1990 process. She also mentioned that in 1990 any graduate (not just pre-85 graduates) who had not obtained a license after being out of medical school more than five years would need to document how they maintained clinical competency.

Speaking from nine years' experience with Illinois Masonic Medical Center's residency program, Dawn Siranovic, house staff coordinator, presented tips to assist program directors in timely receipt of temporary licenses. Siranovic noted steps in the process and stressed the importance of keeping track of applicants.

Supervision of residents addressed

James Weinlader, Ph.D., residency review committee activities director for the Accreditation Council for Graduate Medical Education (ACGME) addressed current and proposed guidelines for supervision of residents, as viewed by ACGME. Dr. Weinlader said program directors are allowed discretion over residency supervision; however, he stressed, "Residents should at all times be properly supervised based upon their level of training."

Rebecca Friedman, chief of Illinois Department of Public Health's division of health facilities, said the hospital licensing board will soon require hospitals with residents to have a supervision policy following ACGME guidelines.

Jamie Berman, legal counsel for Illinois' medical licensing board (MLB), said the department has no definition of what constitutes the unlicensed practice of medicine, but added that each case is assessed individually. "Illinois law requires a license from IDPR be issued in order to practice in this state. If a license has not been issued," Berman said, "the physician's activities may be questioned."



Wm. Daniels/The Photo Partners

Residency program directors discuss licensure and regulation.

Berman noted that since January 1, 1988, the MLB has disciplined 112 physicians for unlicensed activities. She said many who were disciplined graduated from medical school but did not have a license and listed as their job titles "externs," "surgical assistants" or "sub-interns."

Tough decisions and the interview process

Arvind Goyal, M.D., MLB member, spoke at length concerning difficult decisions physicians face as members of the licensing board. He noted that recommending denial or approval of a license is not always an easy decision. "We may know in our heart a person ought to make a good physician, but he does not meet the legal requirements on paper," said Dr. Goyal.

"It's also a tough call whether to grant a license to a physician who makes it on paper, but the quality of education received is really questionable," Dr. Goyal stated. "For example, it's hard to evaluate someone who has done a rotation in a non-teaching hospital with attending staff who have questionable credentials."

MLB requires interviews when there is a discrepancy between information provided by the applicant and medical school or when chemical or drug use or a previous psychiatric history is indicated in the applicant's personal history.

On the question of whether residency program directors should assist these candidates during the interview process, Dr. Goyal said, "If the residency program director can assure us he will take steps after the license is granted to monitor [a resident's drug-free status], it will be helpful to have the director there." He added that the presence of residency program directors can also be helpful to answer questions regarding their program. ▲

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REPORT FOR *Illinois Physicians*

AMBULATORY SURGICAL CENTERS — REVISED PROCEDURES LIST

The Health Care Financing Administration (HCFA) revised the list of covered surgical procedures that permit Medicare payment of a facility fee when performed in an Ambulatory Surgical Center (ASC). The revision was published in the *Federal Register* on June 1, 1989.

The *Federal Register* notice added one surgical procedure, 67105 — an ocular procedure, to the ASC approved procedures list. The notice made ASC facility charges associated with procedure 67105 payable effective July 3, 1989. HCFA has recently directed carriers to reopen claims denied since July 3, 1989, for ASC facility charges for the procedure 67105.

The revision also deleted a number of codes from the ASC approved list because the procedures are normally performed in physician offices. For the deleted procedures, ASC facility charges were made non-payable effective August 30, 1989. HCFA has directed carriers to reopen ASC facility charge claims processed since August 30, 1989, involving the deleted codes. Recoveries will be sought as necessary.

The deleted procedure codes were:

Integumentary System
11200-11201, 11401-11404, 11421-11423, 11441-11444, 11600-11604, 11620-11624, 11640-11644, 11750

Musculoskeletal System
28010, 28011, 28230-28234, 28240, 28270, 28272

Respiratory System
31505

Digestive System
41100

Urinary System
53600-53601
53620-53621
53660-53661

Eye/Ocular Adnexa
67801
68830

Auditory System
69420

An ASC may not charge a Medicare beneficiary for a non-approved facility fee unless the beneficiary was notified in writing prior to the surgery that the facility fee would not be covered. The beneficiary must be given the reason for non-coverage, which, in the case of the recently deleted procedures, would be that the procedure is usually performed in physician offices. Per the waiver of liability rules, the beneficiary must sign the notice accepting liability in order for the facility to bill the patient.

REMINDER: PATIENT EOMB's

Explanations of Medicare Benefits (EOMB's) are sent out to Medicare patients once every 28 days. Please keep this in mind because while you may receive payment on an assigned claim, it may be anywhere from one to 28 days before the patient receives that same payment information from Medicare on an EOMB, based on the 28-day cycle.

This is based on a HCFA cost savings initiative.

(This report is a service to the physicians of Illinois)
12/22/89

Editorials

Soul-searching and the AMA

The American Medical Association (AMA) Board of Trustees is widening its investigation into some questionable financial dealings involving AMA senior staff executives. We at the Illinois State Medical Society (ISMS) applaud this investigation, and continue to urge the AMA to probe deeply in order to clear up any lingering doubts about that organization's management.

In the last year, ISMS has experienced a growing unease with the AMA's effectiveness. ISMS presented the AMA House of Delegates with a resolution at its interim meeting this month, calling for outside consultants to evaluate the AMA's decision-making structures, and to report their findings at the AMA's June 1990 annual meeting. It is important that AMA leadership use that evaluation appropriately, both for the benefit of physicians and because the public at large looks to our organization for direction on medical issues.

ISMS, in organized medicine jargon, is a "unified" state: we stipulate that all our members must also belong to their county medical societies and the AMA. That's because we feel strongly that the AMA has a crucial role to play in advocating high-quality health care and wise public health initiatives at the federal level.

As "unified" members and believers in a strong AMA, we have pressed hard for some objective soul-searching there—focusing not only on the two known financial transgressions, but on the AMA's overall mission, effectiveness and structure.

Of course, soul-searching can be painful. But if conducted honestly, the process can produce a strengthened and improved entity.

While unfortunate financial irregularities precipitated the debate, the AMA should seize this opportunity to re-tool its operation, and begin to rebuild the image of organized medicine.

Going after a tiny minority

The Blue Cross/Blue Shield of Illinois announcement December 5 that it was cracking down on "unbundling" of claims by Illinois physicians was not completely unexpected. Indeed, investigators from BC/BS of Illinois, insurance companies and the federal government had been looking into unbundling for some time (see *Illinois Medicine,* December 8).

ISMS recognizes the need for insurers to implement systems which encourage consistency, integrity and cost containment in billing procedures. We think unbundling is inappropriate when used solely to increase a doctor's income. We also recognize that the vast majority of physicians are honest in their conduct and practices, and do not "unbundle" claims inappropriately. Indeed, as BC/BS officials pointed out December 5, only a tiny percentage of doctors are "unbundling," and most of those are doing so unwittingly, through billing services which code reimbursement claims. We hope that fact is not lost amid all the recent attention to this matter. ▲

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Guest Editorial

Med school admissions on the rebound again—happily



by Richard H. Moy, M.D.

The decline in applicants to medical school is an interesting phenomenon that goes back about 20 years. The frenzy to get into medical school was at its peak in the middle 1970s and then tapered off.

A bumper crop of male college graduates in the early 1970s (due to the Vietnam War) created the appearance of a crush to get into medical school that was really transient. We would have seen a drop-off sooner if it hadn't been for the percentage of women, rising from 10 percent to about 35 percent, where it has stayed.

Colleges, universities and professional schools have followed the demographics and knew that there would be an enrollment dip in the early 1980s and that the population curve would come back up again in the middle 1990s. The drop-off in applications to medical schools was greater than the curve would have predicted. Of course, during the same time, we added about 30 more medical schools.

Are there other explanations for the drop? The Association of American Medical Colleges did a Harris Poll a few years ago of students who had done well on the MCAT but not applied to medical school. The main theme was that these young people had gotten a steady beat of negative messages from their family doctors and doctor relatives that the profession had become all regulation, one couldn't make a decent income, there would be plenty of malpractice suits, and so on. I think another reason is that biology majors number almost half of what they did 20 years ago, which could simply bespeak a change of interest in college students.

Our faculty has noticed an interesting phenomenon in recent years and as I discussed this around the country, just about every dean has identified something similar. The question is "Where have the barracudas gone?" During the 1970s and the early 1980s, every class had a small group of very able but highly aggressive, competitive students that wanted to get out and start making money. They just don't seem to be here any more. Now all of our students seem to be dedicated people who want to take care of sick people.

There have been many questions about medical manpower, and with the drop-off of applicants, there was some talk about possibly reducing enrollment. We may have just enough physicians, or be a little short, or have more than enough, but *nobody can say for sure.* There certainly are wide-open opportunities today, particularly in primary care. Looking at downstate Illinois, we know we can go flat out into the next century with plenty of opportunities.

The decline in applicants seems to have bottomed out last year; we've noticed an increase here. Our Dean of Students' office informs me year after year that there's been no drop-off in quality.

We have not done formal marketing to prospective students, but I don't know that that has much appeal. The feedback we usually get is that our best promotional characteristic is our curriculum, which is the way it ought to be.

We do continue to work hard with minority recruitment. Our biggest problem has been the availability of scholarship funds; frankly, several other midwestern states are out-bidding us. We have gone to the Illinois legislature and there is a bill that would create scholarship funds to make us competitive in recruiting and holding able minority students.

I think there is much ahead to be excited about in our profession and that the relationship which physicians have with their fellow human beings will continue to be privileged and precious. Regulation is probably a permanent fact of life, but young people entering medicine seem to cope better than their predecessors. There is no question in my mind that physicians should be and will be well rewarded by this society. ▲

Richard H. Moy, M.D. is dean and provost of Southern Illinois University School of Medicine, Springfield.

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Grief injects a somber note into some patients' holidays

by Tina Panoplos

THE HOLIDAY season is a time of joy, togetherness and merrymaking—at least for most people. But for those grieving over the loss of spouses, relatives or friends, the holidays can be a time of psychological burden, leading in some cases to physical symptoms. This can be true whether the loss has just occurred, or whether it is years old, and brought freshly back to the individual each year.

While grief is a normal response to the death of a family member or friend, it isn't always acknowledged as such by people dealing with the loss, or by their physicians.

"Some people suffering grief feel that they shouldn't be feeling that way," says Sol Altschul, M.D., director of the Barr-Harris Center for the Study of Separation and Loss and an associate professor of clinical psychiatry at Northwestern University.

People mourning the loss of a loved one, says Dr. Altschul, need reassurance from their physicians that what they're feeling is normal, *not* encouragement to rush into psychiatric care.

Dr. Altschul notes that the period of mourning can last one to two years, at varying intensities. The initial feelings—being angry, upset or wanting to be alone—should calm down after about three to four months. It's when



Scott Wills

the intense grief carries on past five or six months that a person might need psychiatric help.

People experiencing grief might visit their physician with vague physical complaints such as insomnia or loss of appetite, Dr. Altschul says. Physicians can often find out what's bothering patients simply by asking them how they're doing or how they're handling the death of a relative or close friend.

"Most people are perfectly willing to talk about it if given the chance," Dr. Altschul points out.

This is especially true for children, who Dr. Altschul notes are often treated as if they have no feelings. In fact, children who don't seem to react to the death of a parent or sibling are the ones most in need of help, because they're not going through the needed mourning process.

For children, the mourning process often takes longer than it does for adults. This can present problems when a parent is over mourning the death of a spouse but the child isn't. The parent might be ready to get on with his or her life and doesn't want to hear about the child's feelings of anger or grief. But Dr. Altschul says it's important to let children express those feelings.

A grieving child might identify with a lost parent, pursuing that parent's interests or hobbies with some positive outcomes. More often, however, children unable to work through their grief can suffer into adulthood from low-grade chronic depression or problems with their careers or marriages.

Whether a child or adult needs help dealing with grief is something a physician needs to evaulate on an individual basis.

"Don't rush in," Dr. Altschul advises; but if the grieving is too prolonged or too intense or a patient is too withdrawn, then a psychiatric referral might be in order. ▲

Service occupation tax: a clarification

A STORY IN the December 8 *Illinois Medicine* may have inadvertently left the impression that most Illinois physicians are exempt from paying the service occupation tax.

All Illinois physicians who transfer merchandise through their medical service or practice *are* liable for such taxes. Rules effective Jan. 1, 1990 affect the *method* of payment, not the obligation to pay. The Illinois Department of Revenue (IDR) has set a 35 percent threshold dictating the payment method. The threshold may be computed on the basis of a physician's gross sales or on individual transactions.

If the selling price of transferred merchandise *is at or above* the 35 percent threshold, physicians must collect the tax and show the amount on their patient bills. This provision should affect the billing method of only a few Illinois doctors, but those who think they are affected must register with the IDR by Jan. 1.

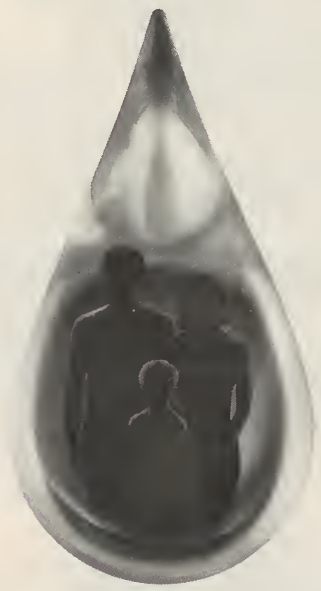
If the selling price of the merchandise is *below* the 35 percent threshold, the tax must still be paid, but physicians may continue to pay the tax directly to their supplier. The only exception is purchases from an out-of-state supplier not registered with the IDR. In that case, the doctor almost must register with the IDR and remit the tax.

Physicians who think they may be affected by any of these changes are urged to consult their tax attorneys or accountants, or to call the IDR at 217-782-3344. ▲

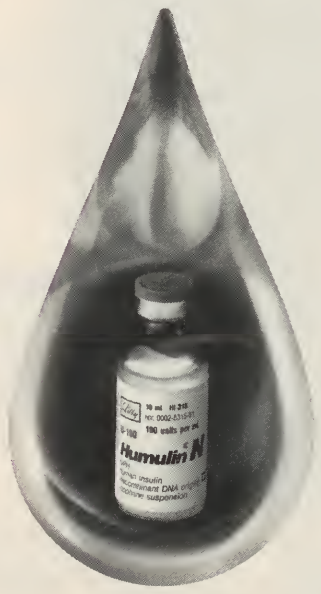
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Psychiatric malpractice: as areas of liability expand, so do lawsuits

PSYCHIATRIC MALPRACTICE litigation, until recently seen by many in the medical profession as something of an exotic variant on the broader theme of medical malpractice, has come into its own. Increasingly, psychiatric patients, their spouses, families and occasionally even their victims, are suing psychiatrists for a variety of reasons (see accompanying box for an index of claims by type).

The alarming growth in these cases, experts agree, should signal psychiatrists to protect themselves from the potential of devastating legal claims and jury verdicts.

"I don't care how good a psychiatrist you are," said Barry G. Bollinger, a prominent psychiatric malpractice defense attorney, recently. "Chances are, you'll get sued."

Bollinger, a founding partner in the Chicago law firm of Brinton, Bollinger & Ruberry, and Robert A. Clifford, president-elect of the Illinois Trial Lawyers Association (ITLA) joined two psychiatrists, James L. Cavanaugh, Jr., M.D., a private practitioner in Chicago, and Mark D. McClung, M.D., a fellow in the section on psychiatry and the law at Rush-Presbyterian St. Luke's Medical Center, in presenting a panel on the subject as part of the Illinois Psychiatric Society (IPS) 1989 Fall Weekend Meeting, held October 28 in Chicago.

Led by Dr. Cavanaugh, the panelists offered a sobering diagnosis. Over the past 10-15 years, they all agreed, legal claims in psychiatry have mushroomed; where psychiatrists once worked in an atmosphere of trust and cooperation, they, like other physicians, are learning to practice defensive medicine.

"The tort liability of the psychiatrist is quite broad," Dr. Cavanaugh told the audience. "Historically, practitioners of verbal therapy were relatively immune from malpractice, but that's beginning to change. There's still clearly a trend toward more vulnerability to malpractice if you're involved in the use of what you might call a biological treatment." But even psychiatrists who use non-drug therapeutic methods exclusively are now being sued, he added.

Among the areas which Dr. Cavanaugh and the other panelists agreed are most litigation-prone for psychiatrists are:

- suicide or attempted suicide;
- injuries to third parties by a current or past patient, when the treating psychiatrist fails to warn the third party or police;
- negligent psychotherapy, which can range broadly in scope from failure to achieve promised results, to an alleged sexual relationship between patient and psychiatrist, to situations in which a psychiatrist supervises the work of residents or students (whose legal responsibility transfers to the supervising doctor);
- consent issues, which in psychiatry frequently arise out of the use of anti-psychotic drugs.

Dr. Cavanaugh said that cases involving consent issues are growing particularly fast. The elements of informed consent include:

- Is the individual competent to give consent at the time?
- Is information given adequate?
- Is consent obtained voluntarily?

In the case of allegations of sexual misconduct, Dr. Cavanaugh noted, many insurance companies that write malpractice insurance for psychiatrists are now specifically excluding coverage for that type of claim. One of these is the American Psychiatric Association (APA) Insurance Trust, which has been insuring between 45 and 52 percent of privately practicing APA members since 1984.

Duty to warn: an Achilles' heel?

Duty to warn or protect third parties is another growing problem. When a current or former patient has harmed third parties, victims have sometimes sued the treating psychiatrist, charging foreseeable danger of harm. After John Hinckley wounded former President Ronald Reagan, the three other individuals wounded in the attack sued Hinckley's psychiatrist.

Fortunately for psychiatrists, the court threw out the case, citing the fact that Hinckley had never named any possible targets. Nevertheless, Dr. Cavanaugh called that a "scary proposition." While "most jurisdictions would still throw out a case like that," he warned, "we're beginning to see a little shift now in cases where those conditions have not been met."

Dr. Cavanaugh noted that legal grounds for suit have expanded since the famous 1976 *Terasoff* case first recognized a duty of mental health professionals to protect potential victims from violence by outpatients. That case, *Terasoff v. Regents of the University of California*, involved a patient who told his therapist of his wishes to kill a former girlfriend, and later carried out the murder.

Dr. McClung cited a number of important recent cases in psychiatric malpractice. In a few, he noted, comparative negligence prevailed: the defense argued the patient had some responsibility and capability for his decisionmaking, and his decisions had some part in damages. Comparative negligence has been used in suicide cases, in which relatives or spouses of patients have sued psychiatrists following suicides, and in third-party injury cases.

Attorneys Bollinger and Clifford, who have faced off against one another in past psychiatric malpractice cases, agreed that it is "perhaps less-qualified attorneys," as Bollinger put it, who are attempting to tear down the legal fences protecting psychiatrists.

In addition, Bollinger and Clifford took on the potentially sticky subject of the psychiatrist's legal relationship to an affiliated hospital. There, they disagreed significantly over whether a psychiatrist faced with a lawsuit should immediately brief hospital counsel on details of the case, apart from simple notification of suit. Clifford said, "It is important to involve the hospital at the earliest possible moment," while Bollinger said, "The hospital has a very different interest from the psychiatrist in looking at potential liability and legal strategies."

Finally, participants agreed that the unique context of therapy places the psychiatrist's notes in a category apart from those of the non-psychiatric physician. Because of this, Bollinger stressed, psychiatrists have special protections not afforded to other physicians. But, he noted, "It's been my experience that psychiatrists take the worst notes of any doctors." Thus, he insisted, there is often real potential for legal harm in the event of a suit. Psychiatrists must not rely on their memories for proof of past incidents and background; legally, he said, such a modus operandi can lead to harsh consequences. ▲

Most Frequently-Occurring Psychiatric Malpractice Claims, by Type

(Cumulative 1984–1989)

1. Allegation of negligent mistreatment
2. Suicides or attempted suicides
3. Misdiagnosis of psychotic or physical illness
4. Improper medications
5. Negligent supervision of patient
6. Negligent confinement
7. Undue familiarity
8. Breach of confidentiality
9. Lack of informed consent

Source of Data: Professional Risk Management Services (administrator of the APA Insurance Trust, Washington, DC)

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

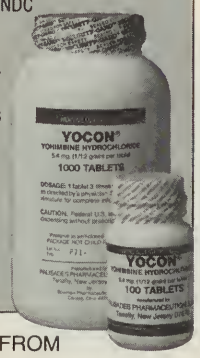
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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1. A. Morales et al., New England Journal of Medicine: 1221 November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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(continued from page 1)

side experts," he said.

James H. Sammons, M.D., AMA's executive vice president admitted that he twice failed to follow appropriate procedures, in approving a $353,000 payment to one AMA senior employee for pension fund stock losses, and in approving a money-losing condominium loan to another. "The manner in which I carried out these decisions was wrong," said Dr. Sammons before the December 3 opening session of the AMA House.

"I want to ask one question so I can go back with a clear heart and clear mind," said George T. Wilkins, M.D., ISMS delegation chairman from Edwardsville, in the December 4 reference committee hearings. "Jim, is there anything that the board needs to know that you haven't told them? We need no more surprises."

"Not that I know of," responded Dr. Sammons.

Joan E. Cummings, M.D., ISMS delegate from Glen Ellyn, testified before the reference committee that ISMS members are concerned about the image of physicians and the effectiveness of AMA's Washington lobbying. "The average member needs a strong national association that gets results," said Dr. Cummings. "The AMA should concentrate on representing members and not making money," she said, referring to the increasing number of AMA profit-making subsidiaries. Alfred J. Clementi, M.D., ISMS delegate from Arlington Heights, served on the reference committee that recommended approval of the AMA board report (entitled Report QQ) and referral for Illinois Resolution 130.

John J. "Jack" Ring, M.D., AMA board chairman from Mundelein, told House members he had no prior knowledge of the two financial incidents. "I am determined that no chairman who succeeds me will ever be faced with the frustrations I have experienced in the past two months," said Dr. Ring emphatically. He received a commendation from the AMA board for his exemplary leadership throughout his term and especially during the most recent controversies.

Report QQ detailed the AMA board's investigation of and actions taken as a result of the two financial incidents uncovered by the *Sun Times*. The AMA board has:

- retained the law firm of Jenner and Block to conduct an independent investigation of the incidents. The firm has subsequently broadened and expanded its probe of the association's financial affairs;
- directed the AMA general counsel to recover money due AMA;
- restructured board committees to strengthen board oversight of the association and to define limitations of the executive vice president's (EVP) authority;
- directed that new outside auditors be retained for 1990;
- accepted Dr. Sammons' plans to retire March 31, 1991;
- instituted a search to find an EVP successor;
- limited the EVP in respect to monetary, compensation and health policy matters to conform to the board's fiduciary responsibilities;
- limited the EVP to approval of expenditures of $100,000 or less;
- directed evaluation and definition of AMA employee loan policies;
- reaffirmed the value of an AMA House committee to oversee routinely the association's finances;
- recognized the contributions to the association by Dr. Sammons;
- promised a report to the House at its 1990 annual meeting.

"This unusually strong report was needed to answer member concerns about how dues are being spent," said Dr. Wilkins. "Such a strong report would not have come out without the Illinois resolution." ▲

Chronology of AMA board investigations and actions

1. On October 29, the Chicago *Sun Times* published news of inappropriate financial payments by the American Medical Association (AMA) to a senior employee.
2. Knowing of the impending *Sun Times* coverage, the Chicago law firm of Jenner and Block had been retained by the AMA board to investigate the incident.
3. The ISMS Executive Committee directed November 1 that a comprehensive resolution be introduced at AMA's December policy meeting, calling on AMA to:
   - —retain independent legal counsel to investigate financial practices relating to various AMA funds and activities;
   - —employ an independent outside consultant to review AMA administration;
   - —redefine AMA's mission statement to make sure the association is representing members in the best way possible;
   - —determine a method to review and improve AMA's policy-making apparatus;
   - —report all findings to the 1990 annual meeting.

   At subsequent meetings, the ISMS board and the ISMS delegation to AMA unanimously supported Resolution 130.
4. On November 19, the Chicago *Sun Times* published details of a money-losing condominium loan to a former AMA employee.
5. On December 3, at the opening session of AMA's House of Delegates meeting in Honolulu, Hawaii, James H. Sammons, M.D., AMA executive vice president and an ISMS member from Chicago, admitted he erred in approving the payment to one senior employee and the loan to another.

   On that day, John J. "Jack" Ring, M.D., AMA board chairman from Mundelein, introduced AMA Board of Trustees Report QQ, which detailed the Jenner and Block investigation, and announced sweeping reforms relating to AMA financial, compensation and health policy matters. Dr. Ring told the House that the AMA board had no knowledge of the financial wrongdoings, and vowed no future board chairman should face such an experience.
6. The AMA reference committee considering the whole issue, including Report QQ and Illinois Resolution 130, convened December 4. Alfred J. Clementi, M.D., ISMS delegate from Arlington Heights, served on the reference committee.

   Joan E. Cummings, M.D., ISMS delegate from Glen Ellyn, gave the lead Illinois testimony, which produced spirited applause. Her remarks affirmed ISMS member concerns about the AMA's mission and effectiveness and stressed Illinois members want and need a strong, credible AMA.

   At the reference committee hearing, Harold L. Jensen, M.D., ISMS board chairman from Frankfort, supported Report QQ, but called for review by outside experts of AMA's administrative, managerial, financial and policy-making processes.

   George T. Wilkins, M.D., ISMS delegation chairman from Edwardsville asked Dr. Sammons if there was anything else the board should know. Dr. Sammons responded there was not, to his knowledge.
7. On December 5, the reference committee recommended adoption of Report QQ and referral of Illinois Resolution 130. The full AMA House referred Resolution 130 to the AMA board "for decision," and adopted Report QQ. The report includes a promise by the AMA board that it will report fully to the House at the annual 1990 meeting.
8. ISMS Delegation Chairman George Wilkins, M.D., received an unusual letter from the AMA board commending Dr. Ring for leadership throughout his AMA chairmanship, especially during the most recent controversies. ▲

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PUBLIC HEALTH REPORT

by Judy Alsofrom

Tuberculosis cases rising

After years of decrease, tuberculosis cases in Illinois suddenly are rising, say worried public health officials.

The situation in the state reflects a trend nationwide, say the officials. After years of a steady six percent decrease in cases across the country with a leveling off in the 1980s, there has been a 2.3 percent increase in cases since 1986, with morbidity remaining for the last few years at about 22,000 cases annually.

Similarly in Illinois, recent increases can be seen most dramatically by comparing figures from the first six months of 1988 with those from the same time period this year. For the first six months of 1988 there were 451 tuberculosis cases reported in the state and for the first six months of this year 515, making the increase 14.2 percent.

For comparison of the same time period in Chicago, public health officials note a 12.5 percent increase in cases, from 272 cases in 1988 to 306 cases this year.

Figures for suburban Cook County remain essentially unchanged, with 48 cases reported during the first six months of 1988 and 50 in the same time period this year.

Chicago's "collar" counties experienced a dramatic 63 percent increase in tuberculosis cases. These counties, which include DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will, went from 46 cases in the first six months of 1988 to 75 in the same time period in 1989. The increase by counties breaks down as follows: DuPage from 10 to 23; Grundy 0 for both time periods; Kane from 4 to 6; Kankakee from 3 to 1 (a decrease); Kendall from 2 to 1 (a decrease); Lake from 17 to 33; McHenry unchanged with two cases from both time periods; and Will from 8 to 9.

The rest of the state's public health regions have reported case numbers remaining essentially unchanged.

A look at case numbers for each year of the 1980s also shows a small but steady and troublesome increase in case numbers after years of decline, particularly in Chicago.

Public health officials nationwide speculate that the worrisome resurgence of tuberculosis cases is tied to the increase of HIV infection in the population, thus adding tuberculosis to the list of opportunistic diseases associated with AIDS. ▲

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FROM THE ILLINOIS NEWS DEPARTMENT OF PROFESSIONAL REGULATION

This information is reprinted from the Illinois Department of Professional Regulation's (IDPR) monthly disciplinary report. IDPR is solely responsible for its content.

The physician and surgeon license of Harold M. Griffiths, 200 Olympia, Warner Robins, GA, was issued on probation after his California medical license was placed on probation and after he practiced in Illinois prior to licensure.

The physician and surgeon license of Walter McFarland, 10810 S. Halsted St., Chicago, was reprimanded and fined one thousand, five hundred dollars ($1,500) after his license expired and he continued to practice.

An order to cease and desist the use of the title Doctor and/or holding herself out to the public as a physician and surgeon was entered for Judith Slankard, 2650 Brookwood Way, Rolling Meadows.

The physician and surgeon license of Howard C. Martin, 7018 N. Sheridan Rd., Chicago, was issued on probation after his medical license was disciplined by the North Carolina Board of Medical Examiners.

The physician and surgeon license of Betsy Chua, 7531 S. Stony Island Ave., Chicago, was suspended for three (3) months to be followed by two (2) years' probation and fined four thousand, five hundred dollars ($4,500) after she was indicted by a Cook County grand jury on a charge of conspiracy to receive kickbacks.

The physician and surgeon license of Joseph P. Dibeneditto, 2148 Antigua Dr., Lexington, KY, was reprimanded after it was found his medical license had been disciplined by the state of New Jersey. ▲

Rural health

(continued from page 1)

portunities; lack of medical supervision of local EMS operations; outdated equipment; poor access to EMS services; and deficient regionalized systems of specialized EMS care, such as trauma care.

Among the OTA's recommendations to address the problem is expansion of existing EMS programs, such as the Department of Health and Human Services (HHS) preventive health block grant program, or the Department of Transportation state and community highway safety grant program. Alternatively, Congress could establish a new EMS program in HHS.

Other options include increased funding to train EMS providers; development of national standards for EMS providers and specialist EMS facilities, such as trauma centers; and increased federal technical assistance to states, linked to the development of comprehensive state widé EMS planning.

Initiatives in the US Senate

Senator Simon is cosponsoring two bills dealing with rural health care issues. Although the Rural Health Care Improvement Act of 1989 is pending, provisions to increase the Medicare hospital service reimbursement rate to three percent above inflation for rural hospitals, and a $0.2 billion additional reimbursement for nurse practitioners, are also included in the fiscal year 1990 budget reconciliation bill, according to Sen. Simon's office.

Also pending is the Rural Nurses Incentive Act of 1989, which would provide direct Medicare payments to nurse practitioners and clinical nurse specialists who practice in rural areas, encouraging them to establish independent practices serving the rural elderly.

Illinois physicians have concerns that the establishment of independent practices could adversely affect the quality of patient care. "The Illinois State Medical Society [ISMS] believes that people should receive appropriate care, including an evaluation of their health, under the direct supervision of a physician licensed to practice medicine in all its branches," said ISMS President Eugene P. Johnson, M.D.

Sen. Simon has also requested a General Accounting Office (GAO) investigation into the causes and consequences of rural hospital closures (see *Illinois Medicine*, March 3, 1989). The GAO study, scheduled for completion in early 1990, will use two Illinois counties as case studies. ▲

Blue Cross

(continued from page 1)

"Many physicians we have contacted," added Dr. Widen, "have expressed surprise that they've had problems. Many physicians use billing services, or do not supervise their own billing procedures," he said. Once physicians have been contacted, Dr. Widen stressed, the overwhelming majority act immediately to get into compliance with BC/BS guidelines.

Dr. Widen said that on January 1, 1990, the new computer system should be fully operational. "At that point," he added, "we can provide a much more accurate estimate" of the scope of the problem.

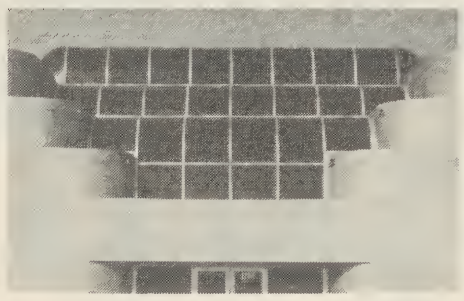
Illinois State Medical Society (ISMS) Third Party Payment Processes Committee Chair Alfred J. Kiessel, M.D., said, "We at ISMS are aware that unbundling has become important to insurers like Blue Cross/Blue Shield of Illinois. We think unbundling is inappropriate if used solely to increase a doctor's income," he said.

Dr. Kiessel stressed, "As Blue Cross/Blue Shield notes, only a very small minority of physicians are unbundling bills. And most of them don't even know their billing services are doing so." Dr. Kiessel said he hopes Blue Cross will take an educational approach with doctors wherever possible.

"All such cases should, however, receive review by a physician," Dr. Kiessel concluded, "because unbundling is sometimes justified due to the complexity of a medical procedure or the coding system." ▲

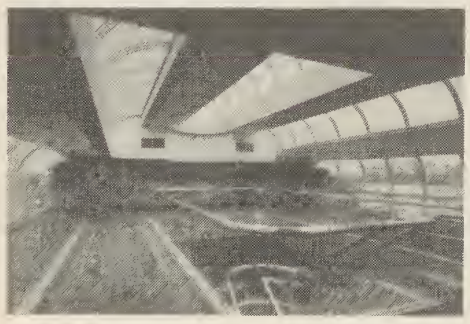
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For sale: Q-Med holter monitor system/real time data analysis. Interspec echocardiogram with doppler. Oxford ambulatory blood pressure monitor. All equipment one year old. Minimal use. Excellent condition. 618/244-7824.

Elmhurst, IL area medical center is available. Owner charges out approx. $690,000 yearly and is collecting an average of $50,000 per month. Services are 20 percent diagnostic testing, 10 percent surgery, 10 percent industrial medicine, injuries, etc., 50 percent general practice and the balance in personal injury cases. The physical plant is over 8,000 square feet with a parking lot to house 40 cars. If more physicians were available, a center of this type and size should easily be able to generate between $2,000,000 and $4,000,000. Call Art Smith at 708/441-6111 for details.

North Cicero Ave., Chicago. This is a general medical practice which is well-established and has been grossing over $150,000 per year. The office is very nicely done with three treatment rooms and is located in a medical building which makes available a surgical suite as well as a number of other convenient services. All equipment is included in the sales price of $72,000. Professional Practice Sales, 540 Frontage Road,Northfield,IL 60093; 708/441-6111.

Geneva, IL area: This family practice has a history of grossing over $230,000 with a net of approx. $100,000. Established for over 23 years. Nice office with three treatment rooms, located in a very nice two story professional building. Well trained staff would stay with new owner. Asking $95,000 for this opportunity. Professional Practice Sales, 540 Frontage Road, Northfield, IL 60093; 708/441-6111.

Near Joliet, IL: This is a busy pediatric practice, with owner seeing 35-40 patients daily and 200 new patients coming in yearly. There are three exam rooms in this well equipped office which is located in a professional building. The area has a population draw of over 200,000 people who are in need of a pediatrician. Owner grossing in area of $260,000. Asking $142,000. Professional Practice Sales, 540 Frontage Road, Northfield,IL 60093; 708/441-6111.

Miscellaneous

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